

**What's special about mental health  
nursing?**

**Being in the here and now, side by  
side, co-constructing care:**

**A substantive grounded theory of  
recovery-focused mental health  
nursing**

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# ***Statements of declaration***

## **Declaration of Originality**

This thesis contains no material which has been accepted for a degree or diploma by the University or any other institution, except by way of background information and duly acknowledged in the thesis, and to the best of my knowledge and belief no material previously published or written by another person except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright.

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## **Statement of Ethical Conduct**

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines by the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University.

3 March 2015

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Pietro Santangelo

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Date

## ***Acknowledgments***

When I first contemplated undertaking research at PhD level, I consulted various Universities to ascertain their interest in my proposed work, their standards in relation to higher degree research, and their access to supervisors who would be actively engaged in the work. I was fortunate in renewing my acquaintance with Professor Mary Fitzgerald through whom I met Associate Professor John Field, both of whom were influential in my choice of the University of Tasmania as the venue for this study. Their encouragement, support and ongoing interest in my work started me on this journey, with John providing expert supervision in the first year of my candidature.

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## ***Abstract***

Mental health nursing is practiced worldwide; however, there is an enduring inquiry, within the discipline that seeks to articulate clearly what a mental health nurse is and does. This thesis explores how mental health nurses describe the nature, scope and consequences of their practice and the meaning they give to what they say and do when asked the question; *what's special about mental health nursing?* Constructivist grounded theory was used to develop a theoretical model of mental health nursing practice, with its focus to conceptualise the lived experience of mental health nursing in terms of its distinctive attributes and positive outcomes for the clients it serves. Data for interpretation were generated through interviews with 36 mental health nurses, five of their clients and one health care colleague. Participants were asked to speak in as much detail as possible about what they believe is special about mental health nursing and what had influenced them to arrive at this understanding.

The study revealed that the distinct nature and identity of mental health nursing provides the foundation that primes and drives practice scope and consequences. The mental health nursing perspective of care is an acquired lens, facilitated by the nexus between the nature of mental health nursing and how it is experienced in practice by those it serves. The participants described a relational interplay between the nurse and the client that facilitates the nurse to adopt recovery-focused practices. Mental health nurses make care available to clients, particularly those with complex needs, that goes beyond what is professionally prescribed for mental health nurses. The result is a client-focused, therapeutic and beneficial coupling that is, concurrently, humanistic and professional, co-constructed and contractual, collaborative and purposeful, and empowering and power sharing that yields positive outcomes.

This brought the study to generate a substantive theory titled '*Being in the here and now, side by side, co-constructing care: A substantive grounded theory of recovery-focused mental health nursing*'. This theoretical construct holds the potential to be the mediating connection between client and mental health nurse. By situating mental health nursing and its central role in practice as something co-constructed, findings from this study can be expanded beyond the Australian context – specifically in terms of professional identity, practice, education, leadership and research.

## ***Conventions used in this thesis***

The following conventions have been used throughout this research study in relation to the general text and the excerpts from the interviews of participants.

Text in single quotation marks'	used for short quotations from the literature.
Indented text in their own paragraph	used for quotations from the literature over 30 words.
Three full stops (...)	used for reading continuity, where appropriate, in the text immediately preceding single quotations over 30 words. In other instances, denotes material edited out from direct quotes.
<i>"Indented italic text in their own paragraph in inverted commas"</i>	used for quotes from participants.
(MHN/Client/HCC participant 'x')	identifies quotes from participants and 'x' refers to the participant's code number used to ensure anonymity.
MHN	refers to mental health nurse.
Client	refers to a client of a mental health nurse participant.
HCC	refers to a health care colleague of a mental health nurse participant.

## ***Acronyms and abbreviations used in this thesis***

ACMHN	Australian College of Mental Health Nurses
AHPRA	Australian Health Practitioners Registration Agency
ARC	Australian Research Council
AVCC	Australian Vice Chancellors' Committee
CHF	Consumers Health Forum of Australia
DoHA	Department of Health and Ageing
FTE	Full time equivalent
MBS	Medical Benefits Scheme
MHNIP	Mental Health Nurse Incentive Program
NHMRC	National Health and Medical Research Council
NHWDS	National Health Workforce Dataset
RANZCP	Royal Australian and New Zealand College of Psychiatrists

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# Chapter 1

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## *Introduction and background*

### **1.1 Issues of concern and interest driving this study**

The motivation for pursuing this research stemmed from an enduring inquiry within the professional discipline of mental health nursing. This inquiry relates to consistent dialogue, by mental health nurses, that while mental health nurses engage in a variety of professional activities, they struggle, at times, to articulate clearly what a mental health nurse is and does. That is, while professional behaviour can be observed and recorded, the essence of this activity that makes it distinctively mental health nursing remains a contested issue within the discipline.

Even in the face of the fact that there is a distinct profession of nursing with specific regulation, standards, codes and educational preparation, and a defined workforce of mental health nurses, this identity inquiry persists. Debates include issues around how it is named, that is whether its practice is 'psychiatric' or 'mental health' (Barker 2006; Cutcliffe, Stevenson & Lakeman 2013; du Mont, Chambers & Collins in Cutcliffe & Ward 2006), its role definition (Barker 1989; Happell 2014; Hercelinskyj et al. 2014; Moe et al. 2013), its professional practice (Boschma, Yonge & Mychajlunow 2005; Browne, Cashin & Graham 2012; Hurley 2009a; Hurley & Lakeman 2011), its professional identity and self-image (Cleary, Jackson & Hungerford 2014; Crawford, Brown & Majomi 2008; du Toit 1995; Hurley 2009b; Madsen et al. 2009; Takase, Maude & Manias 2006; White & Kudless 2008) and its sustainability in the workforce (Hurley & Ramsay 2008; Stickley et al. 2009). These expressed concerns reinforce the importance of defining a rightful identity and place for mental health nursing that acknowledges its distinct contribution. Clarity of these issues is vital for its esteem, integrity and motivation to enhance its practice towards improved service delivery.

While research and theories of nursing and mental health nursing may go some way in explicating this issue, it is argued that there is a need for continuing inquiry in relation to the development of conceptual frameworks of mental health nursing in a context of contemporary professional practice and a changing global landscape politically, socially and technologically.

This research study has been driven by the above circumstances and the broader question of *what is special about mental health nursing?* This question was posed in the context of what constitutes distinctive practice and how this contributes to positive outcomes for whom or what it serves – in short, is it special?

The prime focus of this study was on the special aspects of the nature, scope and consequences of mental health nursing. Its aim was to develop a theoretical model of mental health nursing practice that helped define its distinctive contribution to mental health care and service delivery. The methodology utilised to achieve this was grounded theory, a deliberate choice made in order to go beyond descriptive and exploratory analysis, to theory generation. The details of the methodology, its fit with this research and the methods employed are discussed in detail in Chapters 3 and 4.

## **1.2 Situating myself in this research study**

My background is one of mental health nursing practice over 40 years. The motivation for this research has been facilitated by a lived experience as a mental health nurse, varied professional and career development that has witnessed a broad exposure to practice, and previous mental health nursing research undertaken, each of which is addressed in the following sections.

### **1.2.1 The lived experience as a mental health nurse: An autobiographical connection**

Training in a certificate program in a large psychiatric hospital in Sydney, Australia was the foundational qualification for my mental health nursing. Very early on in this training as a second year nursing student, I was placed in the newly developed community mental health services in the inner city area which afforded greater exposure to direct client assessment, consideration of alternative care options, and more professional autonomy than could be exercised in an institutional setting. This work was executed within a multi-disciplinary team with an emphasis on client-focused care, crisis and early intervention, and an ongoing orientation to community-based care where possible. The opportunity for autonomous decision-making in this practice setting embedded a career long appreciation of the breadth and depth of the scope of mental health nursing practice possible when given the opportunity to

independently express and execute this professional practice. As a result of this experience, it became clear to me that mental health nurses' primary influence and contribution to care was broader than traditionally perceived as secondary service roles prescribed by other professions, usually medical. This reinforced that nurses could be at the forefront of care delivery providing a distinct perspective of care complementary to, but different from, other disciplinary colleagues. Consequently, this in turn engendered my assumption that the scope and essence of mental health nursing practice would be best articulated by nurses who engage the full potential scope of their practice, with as much autonomy as possible, within its professional and ethical boundaries. This assumption has influenced the criteria for selection of the mental health nursing participants for this study described in Chapter 4<sup>1</sup>.

### **1.2.2 Professional and career development: A distinctive nursing focus**

Subsequent to my nursing certificate training, I completed an undergraduate degree deliberately targeting studies in bio-medicine, sociology and politics. This was intentionally strategic on my part to provide a mix of learning that reflected the bio-medical focus of health care as well as looking more broadly at the social determinants of health, very much aligned with the aspirations, albeit largely unachieved, of community-based mental health services at the time. Nevertheless, it imbued an appreciation for a broader perspective of mental health issues beyond a bio-medical paradigm.

Further studies in health service management resulted in a career trajectory that was increasingly more management focused. In these roles, I was influential in the integration of community and in-patient mental health services as well as the initiation of a broader spectrum of mental health services. Services initiated, largely in the 1990s, included child and adolescent and older persons mental health services, acute community intervention and rehabilitation facilities, formal consumer consultant input, psychological trauma therapies, consultation-liaison and emergency department-based mental health services and expansion of acute in-patient services.

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<sup>1</sup> Section 4.8.1 in Chapter 4 describes the rationale for specific selection criteria, for a purposive sample of mental health nurse participants, designed to maximise the potential to elicit data to fully inform the phenomena of interest in this study.

This offered a broad perspective of mental health service delivery and as a nurse manager, I was responsible for nursing workforce growth and development and its justification in a competitive funding environment. These experiences have borne personal witness to a changing health landscape and how nursing has adapted to these challenges. It also reinforced the diversity of nursing practice and its inherent value for its contribution to mental health care. Hence my drive to articulate its distinct contribution.

In more recent times, leadership over eight years (five of these as President) of the Australian College of Mental Health Nurses (ACMHN), the only professional mental health nursing organisation in Australia, afforded me a national perspective of mental health nursing in all its aspects. It provided me an independent view of mental health services not restricted by the policy constraints inherent in an employer/employee relationship in the public health system. This experience promoted my engagement in an even broader dialogue about the professional practice, discipline and place of mental health nursing in health care and has further increased my commitment and effort in promoting mental health nursing as a distinct discipline.

### **1.2.3 Previous mental health nursing research undertaken: A search for new knowledge**

My most recent formal academic pursuit and qualification was a Master of Nursing degree by research in the early 1990s spurred by a health system increasingly pre-occupied with accounting for outcomes of care. The research was a grounded theory study titled, not surprisingly, 'Expected Outcomes of Care: A Mental Health Nursing Perspective'. The question posed by this study was whether mental health nursing practice and knowledge provided a distinctive perspective and contribution to positive outcomes of care in the clinical management of clients with enduring mental illness (Santangelo 1996).

From the data sources used, namely the literature and interviews with experienced mental health nurses, concepts of holistic, consistent and continuous care emerged. This was in the context of a nurse/client caring relationship that modelled not only a therapeutic partnership, but a level of intimacy that contributed to, and was integral to, the therapeutic process. The concepts generated from the data were congregated

to formulate a core concept or core variable which was named the 'nursing care health improvement spiral' (Santangelo 1996, pp. 115-117). Its focus was on the positive impact of mental health nursing care as a process over a time span. The process engaged therapeutic activities in order to facilitate progress for clients with enduring mental illness from a state of dependence on treatment, to a state of independence and adaptation. The psycho-social process<sup>2</sup> and nursing model generated are included as Appendix 1.

There is an obvious progression of interest from this previous research to the present study. The selection of the cohort to inform the present study is similar to the previous study, as is its pre-occupation with a focus on client outcomes and distinct mental health nursing practice. In addition, the interpretation of the data and the findings of the previous study have the potential to intrude into the present study.

The present study provides a design and schema that may progress some concepts from the previous research. Nevertheless, while aspects of each of these research studies share common features and aspirations, the emphasis is entirely different. For example, the previous study articulated the particular mental health nursing interventions that influence outcomes for a specific cohort of clients. The present study is less concerned with the detail of these aspects of care and more concerned with the characteristics that nursing brings to practice, through whatever interventions, to achieve positive outcomes however defined, in a way that may be expressed as distinctively nursing in focus and essence. In addition, the previous study used simulated case studies with specific clinical presentations for three major presentations of enduring mental illness based on psychiatric diagnoses. This was designed as a stimulus for participants to articulate their typical interventions and their expected outcomes. In contrast, the present study uses real accounts of current practice experiences across the whole spectrum of types of presentations and participants' experience, designed for mental health nurse participants to reflect and report on aspects of the care provided that were both nursing in orientation and positive in outcome.

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<sup>2</sup> 'Psycho-social process' is a specific term used in grounded theory to express a process of interpreting, attaching meaning to and explaining interactions of the actors involved. It underpins the inquiry and ties stages and phases of the theory. Other references in the text of this thesis to the term 'psychosocial' denote the generic notion of considering the interconnected influence of social and psychological factors in relation to care delivery.

While the previous study identified some aspects of distinctive mental health nursing practice, it left unanswered questions about the essence and characteristics of mental health nursing that influenced positive outcomes for the clients they served and called for further research to discern these. As such, the previous study was different in focus and emphasis from the present study. This was reflected in its theoretical model that explicated mental health nursing behaviours for a narrow client group. The present study explores more ubiquitous aspects of mental health nursing that may be transferable across differing practice challenges. In addition, it is constructed in a different time. With the lapse of almost 20 years, the mental health and mental health nursing landscape has developed and changed with imperatives for reform and care delivery more advanced.

While the resultant theory generated from the present study could not be predicted ahead of proper data analysis, interpretation and conceptualisation, the expectation of the outcome from this inquiry was one that would result in a novel and broader perspective of practice given the substantially different emphasis, focus and context.

#### **1.2.4 Potential impact of presuppositions on the research**

Nursing theories evolve from extant nursing reality, as seen through the mind of the theorist who is influenced by certain historical and philosophical processes or events ... and ... may evolve from a perception of ideal nursing practice, tinted by one's history (personal, professional and disciplinary) and philosophy (Meleis 2012, p. 32).

It is clear from the foregoing declaration of my personal and professional pathway of career development in mental health nursing that there was a potential for researcher influence on the process and outcome of the research. The impact of this bias could be a negative one if it reflected personal opinion only rather than conceptual development derived from the data. It could also be argued that this background of experience placed me in an appropriate position to ask the pertinent questions in order to explore, interpret and explain the phenomena of interest inquired into. Nevertheless, my lived experience as a mental health nurse has brought to the present study certain assumptions and beliefs about the nature and practice of the discipline and its aspirations towards a clear and positive identity.

Firstly, it was assumed that mental health nurses, who could demonstrate that they had specialist mental health nursing qualifications and experience, were in the best position to comment on the nature, scope and consequences of the discipline.

Secondly, mental health nurses who practiced autonomously were assumed to be expressing professional behaviours that indicated independent decision-making in relation to the advice and care they provided, irrespective of any other dominant paradigm of care that may have impacted on their practice. If less constrained by bureaucratic policies and procedures, mental health nurses could draw on a wide spectrum of interventions and practice and therefore, it is argued, provide an opportunity for them to practice to their full capacity within their scope of practice. That is, participants targeted for this study had the potential to express a broader and deeper realm of mental health nursing practice.

Thirdly, mental health nursing was assumed to have a distinct place and identity in the healthcare workforce, in whatever setting, providing a distinct contribution to care. This study sought to explore and express mental health nursing practice that was characteristic of its particular education, training and experience that added value to the objective of that practice, that is, positive client outcomes. While it is acknowledged that all interventions employed by mental health nurses are not unique to nursing, it was assumed that a nursing perspective may provide qualitatively different care from that applied by other disciplines.

Fourthly, it was assumed that the relationship between mental health nurses and other disciplines practising in the mental health field was a complementary and non-competitive one.

Finally, it was also assumed, that generating a model and theory of mental health nursing practice, that articulated its special properties, was one with which mental health nurses would identify and value and become positively engaged with as a consequence.

Of significant importance to the integrity of the research process was the manner in which interviews were conducted in the data collection phase, and the interpretation of that data in its analysis phase. Personal values, knowledge and assumptions needed to be exposed in a self-reflective process. A means of self-evaluating research credibility and rigour, described in Chapter 3, and attention to the issue of

theoretical sensitivity, described in Chapter 4, provided the safeguards necessary to ensure the integrity required.

## **1.3 A note about nomenclature in this thesis**

References to both mental health nurses and the clients for whom they provide services are prominent in this research study. In addition, the terms ‘professional’ and ‘discipline’ are used and clarification of the use of all the above terms, and the meanings they convey, are outlined in the following sections.

### **1.3.1 Mental health nurse/nursing**

While both terms ‘psychiatric nursing’ and ‘mental health nursing’ are referred to in the literature, for consistency, the term ‘mental health nursing’ is used in the following text (except in a direct quote) to refer to the practice of this specialist group of nurses irrespective of differing attributes of practice.

It is acknowledged that there has been reasoned and meaningful debate about the relative use of the terms ‘psychiatric nursing’, ‘mental health nursing’ or a combination of both, the aim of which has been to refine concepts around practice (Barker 2009a; Barker & Buchanan-Barker 2011; Chambers 2006; Collins 2006; du Mont 2006). Nevertheless, mental health nursing has been deliberately chosen to connote an emphasis on broader concepts of health beyond those defined by psychiatry.

### **1.3.2 Client**

The preferred terms to identify persons with mental health issues who seek professional services are also varied. Terms such as ‘customer’, ‘consumer’, ‘service user’ and ‘person with lived experience of mental illness’ are some. With due respect to these or other preferred terms, in this thesis the term ‘client’ has been deliberately used.

The Macquarie Dictionary (6<sup>th</sup> edition 2013, p. 284) defines a ‘client’ as ‘someone who employs or seeks advice from a professional adviser’. It is this sense that is conveyed by this term in this thesis which explored phenomena about the practice of mental health nursing as a professional discipline. This definition acknowledges that



the engagement and relationship between mental health nurses and clients is a professional one. The sense of 'seeks advice' and 'professional adviser' depicts a relationship that is negotiated on agreed parameters, acknowledging the role of the client's influence on that professional practice for their care.

### **1.3.3 Use of the terms 'profession' and 'discipline'**

In the late 1980s and 1990s, there was considerable discourse in the literature about the professional nature of nursing and its status as a discipline. In the literature, often both terms are used but in particular, much of the narrative addressing these issues relate to whether nursing satisfy the criteria for the status of a discipline. Hardy (1986) critically discusses the adoption and role of theoretical frameworks in attempts to 'bestow respectability and credibility upon our profession' (p. 106) while other commentators examine the pursuit of knowledge through theory development to define the unique function of nursing (Grossman & Hooton 1993; Hayne 1992).

Parse, interviewed by Fawcett (2001), draws a distinction between the 'discipline' and 'profession' of nursing. Parse states that:

The discipline is the knowledge base ... the goal of which is ... to expand knowledge about human experiences through research and creative conceptualization'. The profession consists of persons educated in the discipline according to nationally defined, regulated and monitored standards. People join the profession and practice the performing art (Fawcett 2001, p. 127).

While Parse was referring to nursing as a broad profession, this distinction is useful in discerning the use of these terms in this thesis. Mental health nursing, demonstrated by its name, is part of the profession of nursing. It is argued that it possesses a specific knowledge base in order to practice its 'performing art'. Therefore, when the terms profession or professional is used, they are meant to connote Parse's notion as described above. Where the term 'discipline' is used in relation to mental health nursing, it refers to its specific knowledge base and practice. The term 'professional discipline' is at times used and reflects the inextricable nexus of nursing as a profession and mental health nursing as a specialist expression, in practice, of that profession. The contemporary professional

and specialist status of mental health nursing is addressed in more detail in section 2.1.1 of this thesis.

## **1.4 The use of literature in this study**

The application of grounded theory methodology placed certain parameters around the review and use of literature in the research process. A fuller discussion on grounded theory methodology and methods is the content of Chapters 3 and 4. However, for clarity about the organisation of this thesis and its coherence in terms of flow, it is necessary to describe the way in which the literature was used in this thesis.

There has been considerable debate by grounded theory commentators about the extent and timing of a literature review in grounded theory. This has predominantly centred on the use of literature in the initial stages of the study. Consistent with grounded theory method, it is argued that the researcher should avoid starting by researching the literature about their area of interest too deeply for fear of developing conceptual ideas too early, that is, before data from the field research heard and expressed the voice of the actors living the experience of the phenomena under study (Birks & Mills 2011, p. 22; Charmaz 2006, p. 165; Cutcliffe 2005).

Glaser (1992) asserts the rationale for this approach, reiterating the logic behind grounded theory. He writes:

Grounded theory is for the discovery of concepts and hypotheses, not for testing or replicating them. Thus the license and mandate of grounded theory is to be free to discover in every way possible. It must be free from the claims of related literature and its findings and assumption in order to render the data conceptually with the best fit (p. 32).

Nevertheless, his dictum is not absolute as he makes a number of concessions that would not compromise the integrity of the grounded theory developed. He argues that, firstly, avoidance of a literature review is applicable only in the beginning of the research before coding and analysis. Once a core category is established and theory is sufficiently developed, then substantive reference to the literature in the area of interest can add value, rather than pre-empt or bias the emergent theory. Secondly, he asserts that scholarly literature does not go away so waiting to explore the

literature after theory generation is of no consequence. Indeed, the emergent theory can be enhanced and sharpened by comparing concepts from the literature with those that have emerged from the data, and identifying similarities and differences between them. In this way, the literature acts as additional data for analysis. Thirdly, he advises that reference to literature is encouraged in the beginning of the research as long as it is unrelated literature. That is, literature that does not directly inform concepts about the area of interest before it has emerged from the data, but rather literature that will stimulate thinking in terms of conceptualisation and theory generation. This allows freer capacity for creative thinking and exploration from both the data in the beginning without introducing preconceived concepts, and from later data from the scholarly literature to further refine and enhance the emergent theory (pp. 33-36).

Cutcliffe (2005), in addressing methodological boundaries in grounded theory, supports Glaser's notion of beginning such research with a 'general wonderment'<sup>3</sup> rather than a more defined research question. He explains that the grounded theory researcher at this very beginning phase 'has no preconceived idea of what the key issue or process will be for the people in the area of study', that is, presuming the core process under study prior to data analysis and theory generation, and that this 'openness enables the researcher to be more responsive to the participants' problem' (p. 423). This is not to say that researchers bring an empty mind to their research. Indeed Birks and Mills (2011) assert that there is broad agreement among debating scholars that a researcher enters research ...

... with a broad range of knowledge about their proposed area of study (with much ... drawn from the literature) and neither promotes a thorough review of the literature before undertaking a grounded theory study. We suggest, however, a limited and purposive preliminary review can assist a researcher in the early stages, not the least of which is the early enhancement of theoretical sensitivity (p. 22).

It is also acknowledged that a research proposal most often demands evidence from the literature to justify its support. Charmaz (2006, p. 166) suggests that this

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<sup>3</sup> This is derived from Glaser's assertion that 'the grounded theory researcher ... moves in to an area of interest with no problem ... with abstract wonderment of what is going on that is an issue and how it is handled' (Glaser 1992, p. 22).

information can be relegated to the background until substantive categories, and their relationships with each other, are developed. She also encourages taking a critical stance with literature, allowing this extant knowledge to earn its way into the narrative which she claims is consistent with Glaser's view. She further advises that diligent scholars will cite, from the literature, significant points of convergence and divergence with the generated theory from the study, giving due recognition to other's work. Assessing and critiquing the literature in this manner, often across fields and disciplines, she claims, strengthens the argument and credibility of the resultant thesis.

The treatment of the literature in this thesis has been informed by the above guidelines. My own ambition for this research study was to be genuinely engaged with the questions posed by the inquiry in a way that gave priority to the informants' views in the first instance. Therefore, the preliminary literature review in Chapter 2 was substantially completed prior to the process of analysis and theory generation and served to provide a starting point in describing the setting and context in which the study takes place and some justification for pursuing it at this time. It also provided a platform by which to determine the pertinent questions to ask in order to focus the data generation.

Exploration and review of the literature, subsequent to this preliminary review, is evident throughout those chapters explicating the categories and the grounded theory developed. Therefore, the literature review is not in one place but contextualised to firstly, setting the scene for the inquiry of interest, and secondly, to add value to the concepts and theory developed from the data as a result of that inquiry.

## **1.5 Literature review method**

A broad sweep of the literature using Scopus electronic database was undertaken in the first instance. This technique extracted journal articles of interest and relevance. From this base, more specific searches of the literature were undertaken.

Progressive searching of other electronic databases, with key words to reduce and specify the search, achieved a scan of the contemporary literature that satisfied me that the most relevant material was captured. For investigating the nature, scope and

consequences of mental health nursing practice in the preliminary literature review, key words, used in sequence, were 'nursing', 'mental health' or 'psychiatric', followed by 'nature', 'scope', 'interventions', 'outcomes', 'workforce' and 'Australia'. Similarly, for researching the literature on grounded theory, key words were 'grounded theory', 'method' or 'methodology', 'nursing', 'mental health' or 'psychiatric', and 'Australia'. Later searches of the literature used various key words generated from and relevant to the emerging data in order to further explore specific developing concepts.

Databases scanned included Scopus, CINAHL, Medline via PubMed, Web of Science and PsychINFO. The most contemporary articles were scanned, from each database, for their title relevance and then, if considered relevant, confirmed by reviewing the abstract. The articles chosen were those that addressed issues most relevant to the phenomena of interest in the research study and which provided a breadth of arguments for critical review. Also, relevant articles were sourced from the reference list of articles obtained.

In addition, books authored by the dominant contributors relevant to nursing and mental health nursing in the context of this study were sourced and consulted, as were prominent book authors in relation to methodological issues.

All references were entered into Endnote<sup>4</sup> software and sorted into groups representing particular themes for ease of access.

## **1.6 The organisation and structure of this thesis**

The thesis is organised into seven chapters.

Chapter 1 introduces areas of interest and concern that have driven this study and how I am situated in this research process.

Chapter 2 outlines the preliminary review of the literature that has served two purposes. Firstly, to explain the Australian context in which this study occurs. Secondly, to explore aspects of the beginning question, what is special about mental health nursing, in order to examine where new knowledge was needed and to establish what questions needed to be pursued from participant interviews and other sources of data.

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<sup>4</sup> Endnote is a software tool from Thomson Reuters for publishing and managing bibliographies, citations and references.

Grounded theory methodology, in terms of its epistemology, is described in Chapter 3, as are the ontological considerations for pursuing a constructivist approach. Having established a position in terms of methodology, the methods pursued that properly reflect and fit that stance are outlined in Chapter 4.

The preceding four chapters embody the proposed setting and application of the research process. Chapter 5 concerns itself with the implementation of grounded theory data analysis, drawing from participant interviews to elucidate conceptual categories and their properties interpreted from the data. In addition, data were also drawn from further review of the literature to critique and add value to the concepts generated. It culminates in a core, linking category and explanation of the psycho-social process related to the area of interest in this study.

Chapter 6 consolidates the foregoing data and analysis into the ultimate level of conceptual development to theory generation and integration. Again, the literature was used to place the theory generated in a contemporary context.

The thesis concludes its inquiry in Chapter 7 which reflects on the research process, its findings and implications to mental health nursing, as well as some personal reflections on the research journey.

# Chapter 2

## ***Setting the scene for inquiry***

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The following preliminary literature review was conducted to discover what the literature revealed about the area of interest and concern in this research study in terms of its context and new territory to explore.

### **2.1 The setting in which this study occurs**

The context of this study is an Australian setting. Mental disorders are one of the leading disability burdens in Australia in terms of the number of years lost due to disability. A 2007 national survey of mental health and wellbeing reported almost half of all Australians experienced a mental illness or disorder during their lifetime and one in five Australians, aged between 16 and 85, had experienced mental disorders in the 12 months prior to the survey (Health Workforce Australia 2013, p. 6).

In order to address these significant health issues, a national mental health policy was developed in 2008. It works towards a mental health system that ensures early detection of and intervention in illness, promotion of recovery, access to effective and appropriate treatment for those that need it and community supports to enable them to participate fully in society. The system also supports illness prevention, promotion of resilience and lessening stigma often attached to mental illness (Australian Health Ministers' Conference 2009a, p. i).

Australia's agenda for action in mental health up to 2014 is guided by its current national policy (Australian Health Ministers' Conference 2009b) and is outlined in its fourth national mental health plan. The plan acknowledges the importance of growth in services in the community and primary care settings and adopts a population health framework that recognises 'mental health and illness result from the complex interplay of biological, social, psychological, environmental and economic factors at all levels' (Australian Health Ministers' Conference 2009a, p. 10).

In 2012, Australia's first national Mental Health Commission was established by the Australian Government to 'provide independent reports and advice to the community and government on what's working and what's not' (Australian Government National

Mental Health Commission 2014). It has since provided two 'Report Cards', titled 'A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention' and 'A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention'. These include 18 recommendations for action to realise their vision of ensuring mental health and wellbeing is a national priority, transparent in its reporting, and empowering to people with a lived experience of mental health issues to influence decision-making for system reform (Australian Government National Mental Health Commission 2013).

In addition, work began in 2011 on a national framework for 'recovery' approaches to care that acknowledge the need for those with lived experience of mental health issues to have influence and control over their experiences in mental health services. To this end, a policy and theory document was adopted (Australian Health Ministers' Advisory Council 2013b) along with a document titled 'A national framework for recovery-oriented mental health services: guide for practitioners and providers' (Australian Health Ministers' Advisory Council 2013a). This latter document explains that the intent of this work is to embed principles of recovery into everyday practice and service delivery to create a system 'that puts people with a lived experience at the heart of everything we do and offers consistently high-quality care that has long-term positive impacts on people's lives' (p. iii).

This developing work, on a national level, to meet the challenges posed by mental health issues in the community, also provides an agenda for change and reform for those delivering the care required. The professional disciplines employed in the mental health sector need to be cognisant of these broad imperatives for health care improvement and review and adapt their practice in accord with them.

The development and enculturation of mental health nursing has been influenced by these developments. In an introduction to defining the scope of practice for mental health nurses in Australia, the Australian College of Mental Health Nurses (ACMHN) (2013b) acknowledges the changing environment in mental health services in Australia. It claims the evolution from care in institutions and the shift from a pathology focus to one of health, wellness and consumer self-determination has required ...



... considerable flexibility and adaptability on the part of the mental health nursing profession; and provided greater opportunity for individual mental health nurses to develop expanded and extended roles in the community and primary health contexts (p. 6).

The place of mental health nursing in this context requires clear articulation so that systems of care committed to national goals for mental health can confidently understand and seek the distinct contribution that mental health nurses can make.

The following sections discuss mental health nursing in an Australian healthcare context. While they contain references from outside of the Australian context, there are common themes in the discussion of the nature, scope and consequences of mental health nursing globally that add knowledge and understanding to various contexts of care. This valuable contribution is acknowledged for its commentary on generic issues of concern and their relevance to mental health nursing in Australia.

### **2.1.1 The professional and specialist status of mental health nursing in Australia: Past and present**

In considering the aspirations, identity and practice of mental health nursing in a current context, it is pertinent to reflect and comment on its roots and their impact on its development and socialisation. Therefore, consideration of past influences and their impact on the present professional and specialist status of mental health nursing is explored.

The treatment of mental illness in Australia in the 19<sup>th</sup> and early 20<sup>th</sup> centuries followed a British model which, according to Happell (2007), 'tended to reflect the views of the medical superintendents who migrated to the colonies to oversee the asylums and involved largely custodial care undertaken by un-trained attendants', a role eventually formally associated with the vocation of nursing. She asserts that mental health nursing history is differentiated from the traditional caring role of nurses for the sick or injured because of its foundation of custodial approaches to the treatment of persons with mentally illness (p. 1440).

In the United Kingdom context some 20 years ago, Nolan (1993) reflects on a conservative position of nursing as a profession either not capable of or not ready to assert its own distinct identity. He points out that mental health nurses have been

marginalised in the preceding histories of psychiatry 'despite having had the most intimate therapeutic role in relation to the mentally ill'. He further asserts that history reveals that nurses have never been autonomous, always being 'closely linked to doctors and generally controlled by them' and indeed included as part of psychiatry's history which has served to reinforce subordination to medical paradigms (pp. 1-3).

Similarly, Barker and Buchanan-Barker (2011) propose that the early role of mental health nurses may have been 'created by physicians to provide them with particular forms of support in caring for people in asylums' (p. 1). Nevertheless, they assert, the association with a particular discipline, that is nursing, provided the pathway to a developing discipline consolidating its distinct contribution to mental health care.

In both a past and present context, day to day care for people acutely and/or chronically ill, at varying levels of recovery and constrained in a regulated environment segregated from the general community, presents a specific set of health challenges. This intense and diverse environment requires distinct knowledge and honed skills in the execution of that care. For those providing the ongoing care for these people, association with the nursing profession has provided a framework for practice and allowed and fostered an identity with a recognised professional ethos, set of standards, education and culture that has provided direction for growth, development and self-determination of its practice.

The first mental health nursing training school in Australia was established in 1887 in Sydney's Gladesville Hospital firstly for females only. Males entered a two year program in 1888 and a three year program was established in 1905 (Maude & Warelow cited in Edward et al. 2011, p. 15 referencing Lewis (1988) "Managing Madness: Psychiatry and Society in Australia, 1788-1980"). However, it was not until 1912 that the first Nurses Registration Boards were formed to oversee and regulate training. These Boards were formed in each of the Australian States with their jurisdiction extended only to that State. Queensland was the first State to pass a Nurses' Registration Act and Board in 1912, followed by South Australia in 1920, Western Australia in 1921, Victoria in 1923 and New South Wales in 1924 (New South Wales 1989, pp. 7-9).

From 1986, nursing education in Australia was transitioned to the tertiary education sector which provided comprehensive nursing programs. It is acknowledged that all

registered nurses should have an understanding of mental health issues across all aspects of health care delivery. In pursuit of this, minimum standards of mental health content in curricula for pre-registration nursing education have been set (Mental Health Nurse Education Taskforce 2008). Nevertheless, there has been an ongoing debate in Australia that comprehensive nursing education does not contain sufficient depth in issues around mental health to prepare a registered nurse to work in this specialist area of practice (Cleary, Horsfall & Happell 2009; Clinton & Hazelton 2000a; Curtis 2007; Happell 2009; Happell & Cutcliffe 2011; Happell, Moxham & Clarke 2011; Hayman-White et al. 2007; Moxham et al. 2011; Stuhlmiller 2005; Wynaden 2010).

After the transition to comprehensive nursing education programs, some nursing regulatory authorities in States and Territories in Australia retained an endorsement of 'psychiatric' nursing on the annual registration certificate for those nurses who qualified as a specialist mental health nurse. However, registration of mental health nursing as a distinct entity ceased in July 2010. From this date, registration jurisdiction, which was formerly regulated independently in each of the States and Territories, was consolidated nationally. The legislation governing this is framed within the Health Practitioner Regulation National Law Act 2009 and has been adopted by all States and Territories in Australia. An administrative body, called the Australian Health Practitioners Registration Agency (AHPRA), supports 14 national Boards established in the legislation (sections 31-35) that are responsible for regulating the health professions they represent. The primary role of the Boards is to 'to protect the public and ... set standards and policies that all registered health practitioners must meet' (Australian Health Practitioner Regulation Agency 2014).

One of the 14 Boards is the Nursing and Midwifery Board of Australia which provides regulatory authority over two professions, nursing, which includes the divisions of registered nurse and enrolled nurse, and midwifery. Mental health nurses are identified within the nursing profession so there is no longer a distinct statutory identity of mental health nursing as a specialist stream of nursing. Therefore mental health nursing has no formalised status in Australia. These historical events have eroded the distinct identity of mental health as a stream of nursing that is specialised in its practice. An illustration of this is how the mental health nursing workforce is identified nationally, that is by work setting rather than by specialist educational

qualification. The workforce is determined by registered nurses and enrolled nurses, working in mental health settings, self-identifying as a mental health nurse, irrespective of whether they have undergone any specialist education and training (Health Workforce Australia 2013, pp. 24-25). The lack of differentiation between the number of mental health nurses with specialist qualifications and the broader nursing workforce in Australia is also seen as problematic for workforce planners who are seeking clear and defined skills for the work to be undertaken (Mental Health Workforce Advisory Committee 2011, p. 31).

Writing in the Australian context, Holmes (2006) also alludes to the threats to nursing in the United Kingdom and a trend toward a generic mental health worker. In his paper, he argues that the future mental health nursing workforce 'should be a graduate specialist who stands outside existing disciplinary identities' (p. 401). Hurley and Ramsay (2008), in the United Kingdom context of a threat to eliminate specific mental health nursing undergraduate programs, make reference to the Australian experience. They cite that generic nursing training in the undergraduate curriculum in Australia is 'not adequately preparing students to work in mental health settings, integrates theory and practice poorly, and fosters student identification with adult nursing to the exclusion of other branches' (p. 16).

Attributes that constitute professional status include self-determination by the profession in terms of its ethics and standards, both in practice and education and in legislation and licensing that affect it, and registration with a regulatory body that monitors and enforces practice standards (du Toit 1995; Lakeman 2009). While there is currently no distinct category of mental health nursing defined by the Nursing and Midwifery Board, there is, however, strong advocacy for mental health nursing to be recognised for the specialist services it provides.

The Australian College of Mental Health Nurses (ACMHN) (2010b) in its Standards of Practice for Mental Health Nurses in Australia states that a mental health nurse '... is a registered nurse who holds a recognised specialist qualification in mental health'. Further, the ACMHN states:

Where a nurse meets the minimum requirements, in terms of specialist qualifications in mental health, demonstrated recent experience in the field and commitment to ongoing professional development, s/he may apply for

and be awarded a Mental Health Nurse Credential by the ACMHN. In Australia, new national registration guidelines do not endorse mental health nurses. As a result, the only nationally consistent way of identifying a mental health nurse is through the ACMHN Credential for Practice Program (p. 5).

To date, about 1,100 mental health nurses have been credentialed with the ACMHN which represents less than 6.8% of the mental health nursing workforce (Australian College of Mental Health Nurses Inc 2013a).

The ACMHN's term 'specialist qualifications' implies the attainment of a specific body of knowledge that satisfies professional requirements for mental health nursing in order to provide its distinct practice.

My position in this research study is one that does not take a stand in relation to advocating for a separate specialist profession called mental health nursing, as is the case with midwifery in Australia. Support is given, however, to the process of the ACMHN Credentialing for Practice Program (Australian College of Mental Health Nurses Inc 2010a) which provides a means of self-regulation and recognition of the specialist knowledge, skills, attitudes and experience required to undertake this professional role. The debate about the distinct identity and specialist contribution of mental health nursing needs to be acknowledged, critiqued and further explored. It is asserted that the explication of the essence and nature of mental health nursing, its scope and impact in a contemporary context, as pursued in this research study, is both timely and professionally relevant in contributing to that debate and in reclaiming the identity that is mental health nursing.

### **2.1.2 Political and economic considerations relevant to mental health nursing**

The impact of mental illness on individuals, communities and society as a whole can be substantial. Social problems associated with mental illness include poverty, unemployment or reduced productivity, and homelessness, resulting in experiences by those affected by mental illness, of isolation, discrimination and stigma. In addition, in Australia, the economic cost in 2010-11 was an estimated \$6.9 billion, or \$309 per person, spent on mental health related services, and the annual cost to

employers of reduced productivity has been estimated at 30 million working days (Health Workforce Australia 2013, p. 6).

The Australian government, in its Fourth National Mental Health Plan, articulated its agenda for action in mental health from 2009-2014. Its five priority areas cover social inclusion and recovery, prevention and early intervention, service access, coordination and continuity of care, quality improvement and innovation and accountability through measuring and reporting progress (Australian Health Ministers' Conference 2009a, pp. iv-viii).

The trend in delivery of mental health services is one that favours collaborative multi-disciplinary approaches. (Australian Government 2010; Australian Health Ministers' Conference 2009a). Rigid boundaries in professional values are not necessarily a good fit for purpose for service needs that have complex and interrelated determinants, language and cultural diversity, and aged-related considerations. The care required to provide good outcomes therefore may be demanded of a mental health profession of whatever persuasion as long as the multiple and complex aspects of care are met.

A political and economic environment committed to high quality, accountable and cost effective mental health care will be primed to examine the relative output of the professions delivering that care. In this context, it is likely that current and future workforce models for all disciplines will be open to review. Mental health nursing, as one discipline providing services, will need to firmly establish its identity, collaborative contribution and its cost-effective positive impact in order to be taken seriously in the determination of the future mental health workforce.

Blakeman and Ford (2012, p. 482) refer to the impact of socio-economic forces on 'social inequality, the mechanisms of social inclusion and exclusion, social role and the erosion of resilience' and explore how nurses can participate in ameliorating such negative effects. While they conclude that nurses are well placed in the health care environment to affect changes and reform, they provide little evidence of nursing specific behaviour that contributes to this agenda.

Arguments to support mental health nursing as a significant contributor in the mental health workforce will have to be backed by clear evidence of its value in achieving national goals in mental health as directed by national policy and its supporting

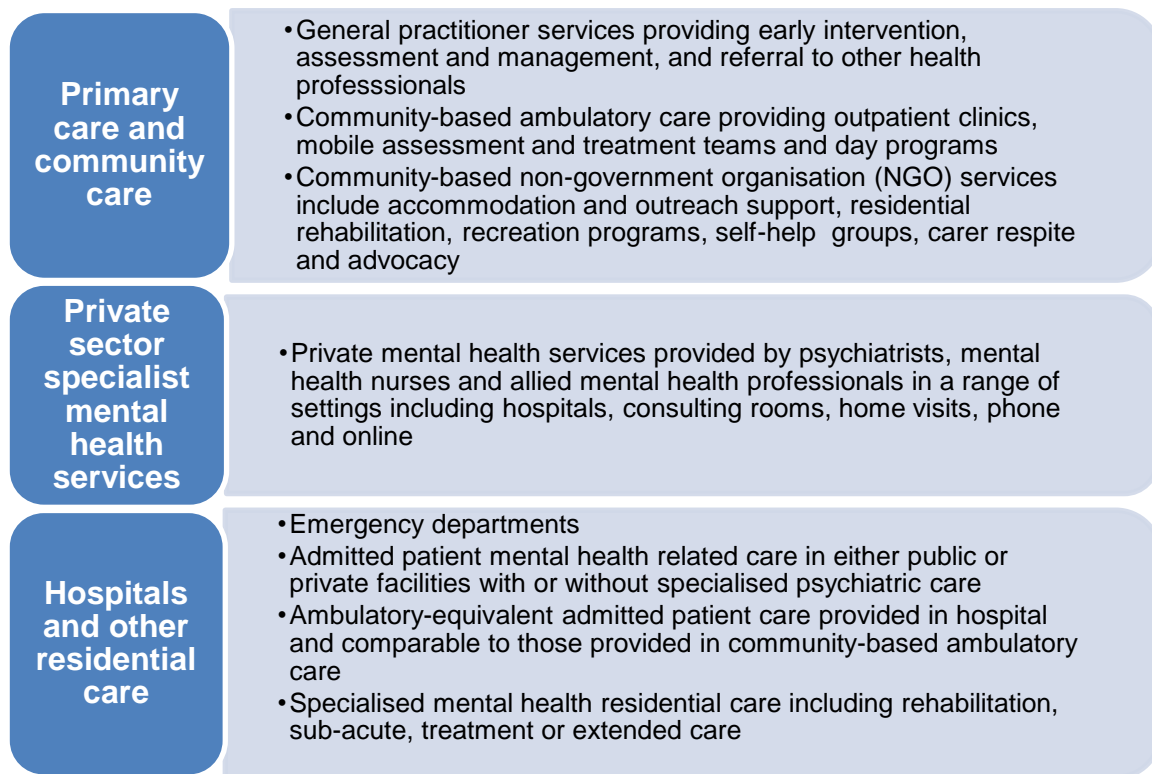
documents for advancement and reform. It is incumbent on all disciplines in providing mental health care to strive to articulate and execute their distinct skills to improve the well-being of the clients in their care. It is argued therefore that, in order to pursue this goal, there is a need for research that explores what a particular professional lens brings for the collective objective of improved client care and outcomes. While this could be seen as a silo approach that does little to participate in the bigger vision for health care improvement, a discipline's preoccupation with identifying its particular contribution is made more meaningful if it is in the context of addressing the basic objective of improving client care and outcomes and portrayed as complementary to other contributions.

Such is the intent embedded in this research study. It acknowledges that mental health nurses are an established workforce in mental health care which brings with it a responsibility to clearly articulate and execute their contribution. The purpose in pursuing this explanation of the discipline is to ensure its own professional objectives are fulfilled while, at the same time, providing an understanding of its added value to others who provide different contributions to care in collaboration and in sync with mental health nurses.

### **2.1.3 The place of mental health nursing in the Australian mental health workforce**

An Australian national mental health workforce strategy was endorsed by the Australian Health Ministers' Conference in September 2011, the aim of which is to 'develop and support a well-led, high performing and sustainable mental health workforce delivering quality, recovery-focused mental health services' (Mental Health Workforce Advisory Committee 2011, p. 1) .

Due to the diverse aetiology and the complex and episodic nature of mental illnesses and disorders, the workforces engaged to meet the needs of clients are many and varied. The service settings in which they work are also varied. Service types identified for workforce planning in Australia are outlined in Figure 1.



**Figure 1:** Mental health service types in Australia (*adopted from Figure 1 in Health Workforce Australia 2013, p. 9*)

Mental health workforce data in Australia are derived from Health Workforce Australia (2013, p. 7) which has established a mental health program of work that includes building evidence on the workforces delivering mental health services. For professions registered with AHPRA, data are gathered on an annual basis in the National Health Workforce Dataset (NHWDS), which is relatively new. For those occupations not registered with AHPRA, information from the Australian Bureau of Statistics Census of Population and Housing is used, which relies on self-reporting. As a result, the data gathered have some limitations. For example, data are not consistently available on all disciplines in the same time period and sources of information on the mental health workforce vary. So it is not possible to estimate the overall mental health workforce at any one time. In addition, how much of a practitioner's time relates to mental health service provision cannot be estimated (Health Workforce Australia 2013, p. 12).

Cognisant of these limitations, the range of disciplines providing mental health services either directly or indirectly, their full-time equivalent (FTE) status per 100,000 population and the data source from which this information is derived is outlined in Table 1.



**Table 1:** Workforces delivering mental health services (*Extracted from Health Workforce Australia 2013, pp. 15-46*)

<b>Primary workforces</b>	<b>FTE per 100,000 population</b>	<b>Year</b>	<b>Data source</b>
Mental health nurses	57	2011	NHWDS
Occupational therapists	38.9	2012	NHWDS
Psychologists	84.7	2012	NHWDS
Social workers	39.7	2011	Census
Psychiatrists	10.9	2011	NHWDS
Registered nurses	616.3	2011	NHWDS
Peer workers (those with lived experience of mental illness)	No consistent national data available		
General practitioners	109.7	2011	NHWDS
Aboriginal mental health workers (no nationally agreed definition or role and qualification expectation for these workers)	No consistent national data available		
Aboriginal and Torres Strait Islander health workers	5.5	2011	Census NHWDS
Enrolled nurses	136.1	2011	NHWDS
Mental health workers (generic term to encompass workers usually in the NGO sector)	No consistent national data available		

The most common disciplines providing direct mental health services are psychiatrists, psychologists, social workers, occupational therapists and mental health nurses. Each has specific qualifications that define, to a large extent, their scope of practice and orientation to mental health care bringing discreet perceptions, knowledge, skill and experience to their role in that care.

Psychiatrists are medically qualified with additional specialist qualifications in the diagnosis, treatment and prevention of mental illness and emotional problems (The Royal Australian and New Zealand College of Psychiatrists 2013). They tend to work in metropolitan areas in the public and private sectors, as do psychologists (Mental Health Workforce Advisory Committee 2011, pp. 12-13).

Psychologists describe themselves as experts in human behaviour using scientific methods to provide psychological therapies. Some specialise in treating people with a mental illness (Australian Psychological Society 2014). Since the implementation of the Commonwealth Government's 'Better Access'<sup>5</sup> program for delivery of mental health services, there has been a steady and increasing migration of psychologists from the public health system to private practice. The average rate of growth in the public sector psychology workforce prior to Better Access was 7.6% per annum, which fell to 4.5% per annum after the implementation (King et al. 2010, pp. xi-xii).

Social Workers, in an Australian context, engage in personal and social interventions with an emphasis on the empowerment and liberation of people to enhance their wellbeing as well as working with individuals, families, groups and communities in the context of their physical, social and cultural environments (Australian Association of Social Workers 2014). For the social work workforce, there was a growing rate in the public sector up to 1,592 FTE social workers by 2007-08. Similar to the psychology workforce, the average rate of growth prior to the implementation of Better Access was 6.3% per annum, which fell to 3.3% per annum after the implementation (King et al. 2010, p. xiii).

Conversely, occupational therapy workforce was the only allied mental health occupation in the public sector to increase its rate of growth following the implementation of Better Access, from 4.4% per annum to 5.6% per annum. In 2007-08, the public sector occupational therapy workforce was 859 FTE persons (King et al. 2010, p. xiv). Occupational therapists promote health and well-being through occupation. Their primary goals are to enable people to participate in the activities of everyday life (Occupational Therapy Australia 2014).

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<sup>5</sup> The Better Access initiative increased the number and range of Medicare Benefit Schedule (MBS) items available to general practitioners (GPs), psychiatrists and allied mental health professionals as a mechanism for increasing access to mental health treatment, streamlining access to mental health services and providing clearer referral pathways for people with high prevalence, non-psychotic psychological disorders.

A mental health nurse, as defined by the ACMHN, has specialist qualifications in mental health and takes a holistic and recovery approach, guided by evidence. Their role with people with mental health issues spans individuals, their family and the community (Australian College of Mental Health Nurses Inc 2010b, p. 5). Mental health nurses are the largest single discipline working in Australian mental health services (Miller et al. 2011, p. 6). Nurses account for the majority of the national workforce in specialised mental health facilities, totalling 51.1%. Nurses made up the majority of the private psychiatric hospital workforce, accounting for almost half of the FTE staff (Australian Institute of Health and Welfare 2009, pp. 138-142).

However, as previously noted, the definition of mental health nursing used for gathering this data is based on nursing activity rather than qualification. Therefore a mental health nurse is an employed registered or enrolled nurse, self-identified as engaging in mental health nursing as their main area of activity. So while they are plentiful in number, there is some ambiguity about what proportion of its workforce is educated to the standard its professional college (ACMHN) supports. This is of some concern as it is evident from the description of each of the disciplines providing care to those with mental illnesses and disorders, psychiatrists and mental health nurses are the two that devote their primary focus to mental health issues. A workforce that does not guarantee an accepted standard of qualification for the work in which it engages requires scrutiny and reform in order to meet its stated goals in client care. To achieve this, it also needs to assert its specialist status and the distinct contribution it makes that is not provided by other professional groups.

The most recent data on mental health nursing found that there was an estimated 19,048 mental health nurses employed in Australia in 2012, or 6.6% of the total Australian nursing and midwifery employed workforce. Of these, 84.8% (16,153) are registered nurses, with the remainder being enrolled nurses. They differ from the general nursing and midwifery population in that there are more men (31.5% versus 10.2% on average), 89.7% are engaged in clinical activity versus 80.1% on average, and their weekly hours are 36.4 hours versus 33.4 hours on average. They are also older with an average age of 47 years compared to 44.6 in the general nursing and midwifery workforce. In addition, nearly half of mental health nurses (47.4%) are over 50 compared to 39.1% in the general nursing workforce (Australian Institute of Health and Welfare 2013, p. 15).

The mental health nursing workforce is also not a homogenous entity in terms of individual qualifications and experience. It includes nurses who have attained their mental health nursing qualifications in hospital-based programs and who may or may not have pursued further qualifications, university educated nurses with or without any specialty training and education in mental health, and nurses who have migrated from other countries who have undergone various programs of education and training (Clinton & Hazelton 2000a, 2000b). They work in a variety of settings, and while the majority works in metropolitan areas, they are in general more evenly distributed than other mental health professionals. There is also widespread support for new work initiatives such as innovative roles in the primary care setting and the expansion of nurse practitioner roles (Miller et al. 2011, p. 4).

The Australian Health Workforce Advisory Committee (2004), in its analysis of key nurse workforce reports, identified a need for action on providing additional nursing positions for the future. Its reports identified consistent findings which included ...

... the ageing of the nursing workforce and subsequent expected retirements over the next decade; and the inadequacy of recent past and current new registered and enrolled nurses to meet projected replacement needs as well as growth in demand for health services in the future. Its initial priority is also the specialised nursing and midwifery workforces, and in particular the areas of critical care nursing, midwifery, and mental health nursing (p. 6).

Projections have been revised to predict and implement strategies for nursing workforce recruitment and retention up to 2025. Nevertheless, projected shortfalls in supply versus demand in 2025 for mental health registered nurses exceed 9,000 or approximately a 40% shortfall in supply. This could be as high as 50% if the Australian workforce is still relying highly on international migration, as it does now, rather than achieving self-sufficiency through domestic training (Health Workforce Australia 2012, p. 27).

It is clear from the foregoing data that the place of mental health nursing in the mental health workforce is one of prominence in terms of workforce numbers and there is increasing demand for their services. It could be argued from this that their distinct contribution to mental health service delivery is acknowledged and established. It cannot be assumed, however, that there is a depth of understanding

about this distinct contribution and that this workforce phenomenon may be nothing other than adherence to traditional recruitment practices. The issue of the quality of this workforce must also be considered in the context of its effective contribution to the clients it serves.

From the data outlined above, it is not clear what proportion of the existing workforce possesses specialist qualifications in mental health nursing. Self-identification with a specialist discipline alone, as a definition of a workforce, is inadequate in terms of assuring quality service delivery. It is argued that recognised specialist education and training should be the minimum standard.

#### **2.1.4 How mental health nursing is perceived**

If mental health nurses struggle to articulate what the discipline does, it is likely that others will struggle to understand its nature and identity. Therefore, the perception of mental health nurses will most likely be determined by what is observed about their professional behaviour and how they project their image.

The social stigma and misconceptions in relation to mental illness and to persons with mental illness is well documented (Bates & Stickley 2013; Mental Health Council of Australia 2011). There is scarce literature, though, to determine whether these social attitudes affect the image and identity of mental health professionals in any way. However, Halter (2002) proposes that mental health nursing, as a profession, is stigmatised in the same way mental illness and persons with mental illness are stigmatised by society. She infers that this is related to their integral advocacy role for persons who are victims of mental illness and societal misconceptions, and which has the propensity to retard the growth of the profession. She asserts that key to the growth of mental health nursing as a profession will be in self and professional knowledge.

She further asserts:

As is always the case with stigma, knowledge is power. The growth and dissemination of a body of knowledge that focuses on how others respond to and experience mental health disorders will benefit the profession and the recipients of their care. Such an approach may have the additional effect of increasing the awareness and value of psychiatric nursing in the minds of

other healthcare professionals, the public, nurse educators, and nursing students (pp. 22-25).

Halter concludes that a 'lack of new knowledge contributes to psychiatric nursing's underdeveloped disciplinary knowing'. In order to re-vitalise the discipline, she purports that 'the development of a knowledge base that more fully describes and supports the art of psychiatric nursing, including the nature of therapeutic relationships, is necessary' (p. 26).

In a later exploratory study, Halter (2008) examined perceptions nurses, working in two general hospitals, of mental health nursing. Mental health nursing was ranked as the area least preferred personally and societally, however this study failed to show a clear case of stigma of the profession by association with the social perception of mental health and illness.

Nevertheless, Gouthro (2009) draws from Halter's propositions to suggest that the stigma associated with mental illness and by association with mental health nurses, 'warrant significant attention in nursing education and research' (p. 674). A very recent study, too, indicates that stigma is a relevant factor in mental health nursing identity (Sercu, Ayala & Bracke 2014).

Halter's allusion to a focus on the nature of therapeutic relationships as a distinct identifier of mental health nursing as a discipline is not new. More than 50 years ago, Hildegard Peplau, often accredited with the title of founder of 'psychiatric nursing', put forward her theory of mental health nursing. Her theses on the central place of interpersonal aspects of nursing are a hallmark of her position and reflected in her major works. In a 1962 article, Peplau (1962b) asserts that nursing roles of 'mother-surrogate', 'technician', 'manager', 'health teacher' and 'socialising agent' or 'technical' sub-roles are secondary to the counselling and psychotherapeutic role of the professional mental health nurse. She explicates this in the context of the professional mental health nurse being defined by post-graduate university education as distinguishable from the basic trained 'duty' nurse and speculates that the future may see ...

... that in another decade or two nurses will share offices with psychiatrists and psychologists and social workers for the private practice of psychiatric

nurse counselling, although now there are no publishable instances of such practices (pp. 50-52).

Winship et al (2009), in exploring Peplau's early career, recount that her thinking about mental health nursing was influenced by the emerging concepts about psychiatry at the time. In particular, she was influenced by social psychologist Erich Fromm who stimulated Peplau's interest in social science rather than natural science. Similarly she was influenced by the social psychiatrist Harry Stack Sullivan and the consequent and subsequent emphasis on psychoanalytic and social approaches to therapy. They state that she 'continued to reaffirm her commitment to the interpersonal psychotherapies, arguing that the nurse herself was the true agent of change rather than the mechanism of the therapy' (p. 511). In assessing the impact of the interpersonal therapy movement in mental health nursing in Peplau's time, they pose that ...

... mental health nursing has rather lost its way and the foundations for good practice that Peplau, Altschul and Skellern discovered through experience, from the gamut of skills from understanding group dynamics to deploying techniques of talking therapy, have been rather misplaced (p. 514).

In more recent times, Hurley (2009b) is sympathetic to the view that interpersonal skills need acknowledgement as a central role of mental health nursing. He reports that mental health nursing identity has been described by 'differing epistemological stances towards mental health, assuming multiple roles, based on relation formation ... and characterised as drawing knowledge from other professions and engaging in roles in response to service-users'. He asserts that a lack of shared professional underpinnings 'result in a professional identity that is difficult to articulate, and thus, difficult to communicate what mental health nursing is to a wider social arena' (p. 384). In his qualitative study in the United Kingdom of 25 mental health nurses engaging in talk-based therapies, Hurley takes a positive position in relation to this professional identity issue. He concludes that while his study supports previous studies that mental health nursing identity relates to the breadth of the role and its user-focused approach, it is the possession of a set of capabilities that distinguishes mental health nurses in delivering talk-based therapies, which was described by one of his participants as a 'generic specialist'. This skill set comprises the use of the

personal self in therapy which is flexible and versatile, and has a basis in time-extended contact and engagement with clients in doing practical and everyday activities and interventions. This enhanced both the engagement and the therapeutic relationship of which the mental health nurse was proud for its distinctiveness in practice (pp. 385-387). Barriers to employment of psychological therapies by mental health nurses in an Australian context have been identified, including an overemphasis on bio-medical nursing practices and lack of training (Fisher 2014).

Crawford, Brown and Majomi (2008) too allude to mental health nurses having professional identity issues and claim that the professional aspirations of mental health nursing have historically been more difficult than in other nursing specialties. They assert that their identity was clearer in the context setting of in-patient services but became more blurred with the advent of community mental health nursing. In their interviews of 34 community-based mental health nurses, they explored their public image, professional aspirations in the context of their work experience, their actions towards professionalisation, and how they identify the central tasks of their occupation. They report that their participants were disposed to allowing their roles to blur and referred to their work in colloquial terms, such as 'a jack of all trades'. They speculate that this may be at odds with developing a clear cut professional identity, instead elevating the concept of 'intrinsic ordinariness' to a level of 'authenticity to their performance'. Yet there seems to be a paradox in the identity of these participants when they express doubt about their professional status when they state that they 'just don't have the clout', and that they 'answer to everybody... yet who goes out and sorts it out when it all falls apart' and 'If we're supposed to be mental health specialists why isn't our opinion sought?' (pp. 1056-1059). Such statements seem to indicate a fluctuating identity of pride in engaging in the ordinary as a legitimate role while at the same time commiserating about being left with roles that no-one else will do and resenting the inherent subservience and powerless that comes with it.

Hurley (2009a) takes issue with Crawford and his colleagues in reference to the term 'jack of all trades', asserting that this may not detract from a firm professional identity but can be re-framed in the context of an identity of mental health nurses as 'multi-skilled'. He argues that:



This identity marker of generic specialism represents a genuine area of mental health nurse co-construction between practitioners and policy, consequently alerting all to the worth of mental health nurse role flexibility (p. 292).

Hurley's re-frame projects a stronger and positive image of the roles undertaken by mental health nurses. It is argued that research that aims to explain the nature of the profession and its distinctive practice, will add to its positive identity as a result. It is this new knowledge that is being sought in this research study. In so doing, it is anticipated that this will assist the discipline to better articulate the essence of its practice, thereby increasing a level of understanding not only to the discipline itself, but to others in both the health arena and the general community.

### **2.1.5 Paradigms of care influencing mental health nursing identity**

The dominant paradigm of health care in Australia is, not surprisingly, a medical one and mental health is no exception. This begs the question whether this cultural and systemic dominance compromises the voice of mental health nursing in espousing its own models of care.

There has been much debate in relation to how willingly the discipline of mental health nursing acquiesces to a medical paradigm of care in preference to articulating a distinctive paradigm that is recognisably 'nursing'. In reference to nursing empowerment, Lewis and Urmston (2000, p. 211) assert that there is widespread acceptance that nurses, as a whole, are in a subservient position to administrators and medical staff despite the differing beliefs about how they exert power over patients, doctors and other health care staff. Commenting on Barker's position on nurses' place in organisations, Grant (2001, p. 174) argues that while mental health nurses are necessarily engaged in decision making about their practice, such decision making is nonetheless constrained by the medically led hierarchy in which they practice. Clarke (2001, p. 179) argues that nurses are comfortable in a relationship of deference to the medical model because they believe in it and hence nursing education has failed to embed theoretical frameworks that question the medical role.

Wilkin (2001) too is critical of the medical patriarchy of psychiatry arguing its credibility is built on the bedrock of positivism and based on self-interest. In spite of increasing sophistication of mental health nursing practice and calls to reject this model, Wilkin states that mental health nurses 'continue to be propelled by the twin engines of illness and diagnosis' and retain 'the disabling medical mindset that perpetuates psychiatric colonialism' (pp. 115-118).

Barker and Buchanan-Barker (2011) confer with this issue in an historical context. They argue that not much has changed over the last century when mental health nursing was confined to custodial roles in asylums led by physicians, despite an attempt by mental nursing to assert its expertise and professional identity. They purport that still the nurse's primary function is 'to keep people (and others) safe; to express medical treatment; and in hospital settings, to 'manage' the physical and social environment', the stereotype of the 'housekeeper' (pp. 1-3). They further argue that nurses perceive the medical paradigm as valid and useful, adhere to it and fail to challenge it because it carries the stamp of medical authority.

The medically based training and socialisation of nurses, whether they have internalised or sought to challenge it, argues Beresford (2004, p. 365), has been a central feature of mental health nursing. Medically based knowledge is, and has always been, present in nursing and rightly so for its scientific contribution to understanding illness processes. Contemporary interpretations of health, involving a range of determinants, need to go beyond narrow definitions of the dominant scope of medical models, particularly for mental health nursing where the nature and purpose of practice is more than just illness management. Nevertheless, Coffey and Hannigan (2013) propose that, mental health nurses, in contemporary practice, can still be challenged by attempting to achieve a balance between fulfilling biomedical and social roles in their practice.

Hildegard Peplau (1962a), was less concerned with what nursing is and more with what is the emerging scope of nursing. She asks that if nurses don't know what nursing is, who does? In this context, she noted that nursing was at a critical point and ...

... must choose soon whether it will maintain its subordinate position as a practitioner, or whether it will change the concept of nursing and promote

colleague collaborative relationships between nurses and the other established professional practitioners (pp. 16-25).

In a more recent text, it is claimed that a number of countries have developed policies providing nurses with the impetus for new directions, and university nursing education is now propelling nurses toward adoption of independent discipline-focused models of care which are increasingly becoming independent of the medical model (Nkowane & Saxena 2004). In a current Australian context, the debate about mental health nursing education focuses on adequate mental health content in all nursing curricula as well as specific and targeted areas of study to adequately prepare mental health nurses for their specialist role in improving client outcomes (Happell 2011; Happell & Cutcliffe 2011; Happell, Moxham & Clarke 2011; Moxham et al. 2011; Neville & Goetz 2014; Wynaden 2010, 2011). In the absence of a detailed analysis of the content of all curricula, it can only be assumed that there is an emphasis on determinants of mental health that is not restricted to medical knowledge alone. How well these curricula represent an independent nursing model of care is left to conjecture.

So it seems that the debate around the image, profile and essence of mental health practice is alive and well. It is speculated that mental health nursing practice is not consistently applied over its different practice settings. This makes contemporary attempts to develop a uniform or universal schema of mental health nursing practice fraught with contextual variables. Due to such diversity, it is surmised that one single culture of mental health nursing is not arising in the face of various cultures of care. This invites further research and exploration of a cohort of nurses who fulfil, in their practice, criteria that may define distinctive nursing work irrespective of the setting. This is one of the challenges that this research study attempts to address.

### **2.1.6 Programs in Australia supporting independent mental health nursing practice**

In Australia, the majority of mental health nurses work in the publically funded healthcare systems and they are the largest discipline in privately funded healthcare settings (Miller et al. 2011). In such settings, the independence and autonomy of practice is mediated by policies and procedures that arguably confine practice within

certain parameters of care and is influenced by the dominant paradigm of care, largely medical.

Some mental health nurses practice in sole private practices on a fee for service basis. In July 2007, the Australian Government's Department of Health and Ageing (DoHA) introduced a national program called the Mental Health Nurse Incentive Program (MHNIP). On its website, it describes the program as providing ...

... a non-MBS (Medical Benefits Scheme) incentive payment to community-based general practices, private psychiatrist services, Divisions of General Practice, Medicare Locals and Aboriginal and Torres Strait Islander Primary Health Care Services who engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders. The intent of the MHNIP is to ensure that patients with severe and persistent mental illness in the private health system receive adequate case management, outreach support and coordinated care. The MHNIP also assists in relieving workload pressure for general practitioners and psychiatrists, allowing more time to be spent on complex care (Australian Government Department of Health and Ageing 2013).

While again mental health nurses working in the program are technically under the direction of their medical colleagues and subject to influence by the dominant medical paradigm, this context of care in the primary health care setting allows fewer constraints for mental health nurses than in more bureaucratically managed organisations. One mental health nurse working in this program has given voice to this:

The MHNIP has given me a new lease of life. It allows skilled nurses to express themselves and deliver a genuine holistic approach to the most vulnerable in our community. The GPs at my surgery often comment on how useful it is having an accessible social worker/psychologist/psychiatrist/counselor/advocate/crisis team on the premises all for the price of ONE mental health nurse! (Australian College of Mental Health Nurses Inc 2011, p. 19).

In its formal evaluation of the MHNIP in 2012, DoHA acknowledged the effectiveness of the program in terms of its appropriateness to the target group, its model of care

and its positive impact on client outcomes, as well as its economic efficiency (Australian Government Department of Health and Ageing December 2012, p. viii).

The MHNIP has also had an important impact on the identity of mental health nurses wishing to work independently. It has given them a mechanism by which they can identify their practice as a nurse, rather than under some other title such as counsellor or psychotherapist and the like, albeit often undertaking the same sort of work.

It was anticipated that this research study would attract mental health nurses working in the MHNIP as participants because the participant criteria includes specialist education and training as well autonomous working practice.

## **2.2 Formulating the relevant inquiry**

The issues of interest that led to this inquiry relate to the sustainability of the professional identity of mental health nursing as a specialist area of practice, its rightful place in the current and future workforce, and its positive impact on client outcomes as a result of its distinct contribution.

Descriptions of mental health nursing most often allude to attributes of practice rather than articulate the essence of the discipline. In the United States of America 'psychiatric-mental health nursing intervention' is described as 'an art and a science, employing a purposeful use of self and a wide range of nursing, psychosocial, and neurobiological evidence to produce effective outcomes' (American Psychiatric Nurses Association (APNA), International Society of Psychiatric-Mental Health Nurses (ISPN) & American Nurses Association (ANA) 2014).

Similarly, the Australian College of Mental Health Nurses (2010b) in its standards for practice describes the discipline in terms of what it does, more than what it is, and states that a mental health nurse ...

... holds a recognised specialist qualification in mental health ...taking a holistic approach, guided by evidence ... works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual (p. 5).

Such definitions, while useful, do not go far enough in profiling the essence of what is mental health nursing, that is, its intrinsic nature and important elements and features. Nor do they explain the 'general wonderment' of this study about what is special about mental health nursing.

In order to explore further the areas of concern relevant to this question, a preliminary review of the literature was conducted to examine the nature of mental health nursing, its interventions and outcomes, as well as the scope in which this practice is defined.

### **2.2.1 The nature of mental health nursing: The confluence of art and science**

There is much discourse in the literature about the nature of mental health nursing. This discussion takes a number of forms, some defining aspects of the work performed, (Jinks & Chalder 2007; Nkowane & Saxena 2004; Nolan et al. 2004; Nolan, Haque & Doran 2007), the depth and level of skills and abilities required, (Grigg 2001), and the discipline's core elements (Kermode 1995; MacNeela et al. 2010). Some specific interventions, such as 'touch' and its therapeutic value are described (Gleeson & Higgins 2009). Nevertheless, most descriptions of the role of the mental health nurse, claim Brunero and Lamont (2010), are limited by simply explaining what the mental health nurse does, rather than explaining the underlying approach and evaluation of the model suggested.

A common analysis often examines a dyad of nursing practice expressed as nursing 'art' and 'science'. In a qualitative synthesis of 59 English-language narratives from 1982 to 2006, Finfgeld-Connett (2008a) found that the art of nursing consists of expert use and adaptation of empirical knowledge, the science of which underpins the art of nursing. This notion of 'art' is derived, she claims, from metaphysical knowledge and values and less formally acquired insights that are gleaned from nurses' unique experiences and innate senses. The practice of 'artful nursing', she says, is relationship-centred and involves sensitively adapting care to meet the needs of individual patients, and in the face of uncertainty, the discretionary use of creativity (p. 383).

Finfgeld-Connett (2008a) also describes nursing in terms of its values and attributes and their relationship to the 'art' of nursing. Values underpinning nursing, she argues, include holism (attending to physical, psychological and spiritual needs of patients, families and communities), a tradition of acceptance and respect, honouring personal choices of the patient who is empowered to make their own decisions, and promoted through patient advocacy and the instillation of hope. Attributes are linked to relationship-centred practice, with an 'intimate' connection characterised by deeply sensing another's situation and seeking out underlying issues, and the nurse, she says, 'is attuned to and synchronised with each recipient of care' and makes inferential judgments about potentially desirable outcomes. Kindness, compassion, healing touch, humour and thoughtful doing are exhibited (pp. 383-384). In addition, she uses the term 'artful nurses' who are ...

... not unduly restricted by standardized procedures and practice guidelines ... but ... have the aptitude to navigate ambiguity and handle challenges ... and are able to institute care that is not always directly inferred from empirical evidence. They are capable of taking calculated risks based on non-analytical realms of knowing (p. 384).

The empirical knowledge underpinning nursing practice will invariably come from a variety of sources derived from different disciplinary research, including nursing. As such, not all of this knowledge can claim to be distinctively nursing. However, as argued by Hurley (2009a, 2009b), the accumulation and coordination of this knowledge is used by mental health nurses in practice in distinctive and productive ways. It can also be argued that the 'art' of nursing, based on values embedded in the metaphysical knowledge and values acquired by nurses in practice as described by Finfgeld-Connett, has the potential for differentiating nursing from other disciplines.

Barker (2009a) proposed that mental health nursing is a confluence of science and art, marrying these two elements to form a notion of a blended practice. He refers to the 'craft of caring', that is, the practice of nursing requiring both 'knowledge (science) and aesthetics (art)' which are blended to form a craft. He asserts that craft workers 'use their skills and knowledge to satisfy the demands or expectations of

patrons and customers while satisfying their own aesthetic and technical ambitions' (p. 7).

Further drawing on this theme Norman and Ryrie (2009), in arguing for a new public mental health nursing role in the United Kingdom context, draw on the collaboration between the notions of ...

... an 'artistic' interpersonal-relations tradition which emphasizes the centrality of nurses' therapeutic relationships with 'people' 'in distress', and a 'scientific' tradition concerned with delivery of evidenced-based interventions that can be applied to good effect by nurses to 'patients' suffering from 'mental illness' (p. 1537).

The concept of 'caring' is also a constant theme in the nursing literature. Forrest (1989) conducted a phenomenological study of nurses related to 'what is caring' and 'what affects caring'. Forrest proposes that nurses' caring comes from a 'deep interest in humanity' and is experienced as a 'mental and emotional presence' which influences their preferences for interaction with their clients as 'being with' rather than 'doing to' (p. 818). Fingeld-Connett (2007) concluded that 'caring' appears to reside within the professional paradigm of nursing. In a later publication (2008a), her investigation of the concept of caring found a cohesive process of caring could be explicated and offer clarity about its therapeutic benefits.

Another concept that is described in the literature in terms of the nurse/client interactional process is that of 'presence'. Presence, according to Fingeld-Connett (2006b, 2008b, 2008c), is an interpersonal process that is characterised by sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances. It consists of a process in which patients demonstrate a need for and openness to presence and should be distinguished from the notion of 'caring', although she later concedes that distinguishing features between the two concepts are not significant (2008c).

Chiovitti (2008) claims the mental health nurse's perspective on caring has been absent from theoretical works and the concept of caring is described as intangible, abstract, and invisible in nursing practice. She developed a grounded theory of a 'protective empowering' psycho-social process through which registered nurses expressed their caring with patients in acute psychiatric hospital settings. She



identified underpinning categories necessary for caring to occur, namely 'respecting the patient' and 'not taking the patient's behaviour personally'. Four other categories were identified that represented the context through which caring occurred, namely 'keeping the patient safe, encouraging the patient's health, authentic relating and interactive teaching' (pp. 203-209).

Barker (2009a) reinforces the central role of caring in practice and proposes that it remains the universal, common denominator of mental health nursing, in contemporary parlance referred to as therapeutic activity. He posits that when nurses 'help alleviate distress and begin the longer term process of recuperation, resolution and recovery, those activities become therapeutic, engendering the potential for healing' (p. 9).

### **2.2.2 Defining distinct practice**

Cowman, Farelly and Gilheany (2001) claim that role ambiguity and poor role definition is an enduring theme in the mental health nursing literature. They argue that understanding of the discipline is incomplete and that the knowledge and skills base required for independent therapeutic mental health nursing practice needs to be determined. Deady (2005) also asserts that there is limited evidence to support a formalised philosophy in mental health nursing which he describes as being in a pre-paradigm state. It is also claimed that there is a rhetoric-reality gap in mental health nursing practice in that what is said to be done is in fact not practiced (Skidmore, Warne & Stark 2004). This is reinforced by Barker and Buchanan (2011) who argue that while people claim they know what mental health nursing is and value it highly, they cannot describe or define it other than in vague terms.

While Littlejohn (2003) supports an autonomous and independent profession of mental health nursing, not all authors agree that this should be the central concern. They assert that the focus of discussion, in terms of mental health nursing practice, ought to be on collaborative efforts in a multi-disciplinary context rather than on pursuing a unique or distinctive nursing body of knowledge (Cutcliffe & Happell 2009; Priest et al. 2008).

In pursuing a distinctive role of mental health nursing, Jackson and Stevenson (2000) explored examples of effective and ineffective nursing interventions and

concluded that further study was needed to explore how nurses predict patients' expectations of them, using a symbolic interactionist framework. Similarly, Crook (2001) claims that the literature is deficient in describing the nature of mental health nursing expertise and calls for a model that bridges the gap between theory and practice and makes sense of the informal theory that is generated through practice. It is these aspects of inquiry that this research study attempts to address.

### **2.2.3 Mental health nursing interventions and their outcomes**

Several studies on mental health nursing interventions focus on the issues of medication management. These include the management of side-effects and often with a particular focus of promoting client adherence to medication regimes in order to prevent relapse of illness (Anderson et al. 2010; Bobier, Dowell & Swadi 2009; Gray et al. 2010; Jones et al. 2006; Montes et al. 2010; Wijnveld & Crowe 2010).

This biomedical paradigm and focus of care is mirrored in another study that analysed nursing records to understand the structural and social processes in care. According to the nursing documentation, biochemical interventions in the form of various medications were the most dominant means through which nurses attempted to restore or improve the functional capacity of an activity of daily living (Hyde et al. 2006).

Other studies focus on evidence-based interventions that may be delivered by nurses (Jung & Newton 2009) such as narrative therapy (Aloi 2009), solution focused brief therapy (Wand 2010), exercise programs (Tetlie, Heimsnes & Almvik 2009) and use of humour (Struthers 1999).

Management of aggression and difficult behaviours is also addressed (Bowers, Alexander, et al. 2007; Bowers, van der Werf, et al. 2007; Finfgeld-Connett 2009; Foster, Bowers & Nijman 2007). So too is collaborative care with clients and carers with an emphasis on client empowerment and improvement in client outcomes (Bauer, Biswas & Kilbourne 2009; Finfgeld 2004; Macleod, Elliott & Brown 2011; O'Neill, Moore & Ryan 2008).

A biomedical theme continues in the literature related to outcomes from mental health nursing interventions. One integrative literature review examined empirical studies, published between 1997 and 2007, and appraised 156 articles of which 25

met their inclusion criteria. Findings from this review showed that the most frequently used outcome instruments assessed psychiatric symptom severity (Montgomery, Rose & Carter 2009).

Literature reviews accessed, highlighting the nurses' role in improved outcomes for clients, focused on early interventions strategies in relation to first-episode psychosis (Reed 2008; Repper & Brooker 1998) and mental health interventions for older persons (Thompson, Lang & Annells 2008).

Other studies examined outcomes where nurses used established evidence-based interventions such as cognitive behavioural therapy (Malik et al. 2009), psychosocial interventions training for nurses (Redhead et al. 2011), and formal observation (Manna 2010). Outcomes related to consultation/liaison mental health nursing is also explored. One of the papers was a randomised control trial (Cullum et al. 2007) while others examined mental health nursing interventions, and their outcomes, used by psychiatric consultation-liaison nurses (Yakimo, Kurlowicz & Murray 2004; Zolnieriek 2009). Other contexts of care, such as government community mental health services and primary health care services have also been explored in terms of their impact on client outcomes (Badger et al. 2003; Bowers 1997; Huxley et al. 2003; Weaver et al. 1999).

Specific and quantifiable outcomes are often difficult to measure in a mental health context because of the multi-factorial causes for mental illnesses and disorders and consequently the range of variables that may determine outcomes. A common theme in the above papers is their inconclusiveness in terms of outcomes as a consequence of mental health nursing specific interventions with a call for more research in this area. It was expected that exploring the nature of mental health nursing interventions within a frame of their positive outcomes for clients, as this study does, may provide a conceptual explanation of the productive and distinct process that is mental health nursing.

#### **2.2.4 Mental health nursing scope of practice**

The scope of mental health nursing is addressed and determined by various aspects of its practice. The American Psychiatric Nurses Association and allied organisations (American Psychiatric Nurses Association (APNA), International Society of

Psychiatric-Mental Health Nurses (ISPN) & American Nurses Association (ANA) 2014) has a scope and standards of practice document which describes current trends and issues influencing nursing, different levels of practice and its various settings for mental health nurses in their country. There are some scoping studies in the United Kingdom and Europe (Jinks & Chalder 2007; Nolan, Bourke & Doran 2002; Nolan, Haque & Doran 2007) and one scoping study on the mental health nursing workforce in Australia (Clinton & Hazelton 2000b). The Australian study examined Australian mental health nursing workforce characteristics however noted that 'assessments of the number of mental health nurses within a jurisdiction are meaningless without a clear understanding of the roles and scope of practice of mental health nurses' (Clinton & Hazelton 2000b, p. 1).

Broad practice parameters for mental health nursing are explicated in the ACMHN Scope of Practice of Mental Health Nurses (2013b) incorporating its 2010 National Standards of Practice for Australian Mental Health Nurses. In addition, the ACMHN asserts that the advent of community mental health nursing practice in Australia has created an environment where ...

... nurses frequently experience more autonomy and work independently compared with nurses employed in hospitals. The once clearly defined professional roles have become blurred and limited literature suggests that community nursing roles have expanded beyond the traditional scope of nursing practice (Elsom et al. 2007, p. 324).

Much of the literature related to mental health nursing scope of practice, though, is in relation to advanced or extended practice<sup>6</sup>. Studies address issues such as the role and education of nurse consultants in the United Kingdom (Woodward, Webb & Prowse 2005), a distinct and autonomous role for nurse practitioners (Elsom 2006; Elsom et al. 2007; Wand & White 2007; Weiland 2008) and the extent and impact of role extension (Elsom, Happell & Manias 2009a, 2009b; Happell et al. 2009).

Nevertheless, the focus of attention in these studies is expansion of the nurse's role into areas traditionally performed by the medical profession, such as prescribing medications, diagnosis and referral to other specialist medical practitioners. In

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<sup>6</sup> It is acknowledged that what defines advanced or extended practice in the literature is not always clear (Elsom, Happell & Manias 2005; Jinks & Chalder 2007).

addition, this is often in the context of workforce shortages of medical officers providing a pragmatic argument for nurses to adopt these roles. While this focus positions nursing in a context where access to care and interventions are potentially enhanced toward better client outcomes, it is still bound by a dominating biomedical paradigm within which nurses are practising.

The challenge that this discourse poses for this research study is that it seeks a model of nursing that comes from its own paradigm of care; a distinctive lens that is not competing with any other but is rather complementary to other paradigms, and as a result, adds value to the pursuit of better outcomes for clients.

### **2.2.5 Distinct mental health nursing practice: New knowledge to explore**

From the literature in the previous sections, common themes have emerged that identify areas for further research and exploration that are relevant to this study's inquiry.

#### **2.2.5.1 Descriptions of roles and functions do not identify the essence of nursing**

While definitions of mental health nursing exist, they tend to describe what it is that mental health nurses do. Such definitions, while useful in describing a scope of practice, do not go far enough in profiling the essence of what mental health nursing is. It is asserted that few studies explain the underlying approach and evaluation of the model suggested (Barker & Buchanan-Barker 2011; Brunero & Lamont 2010).

At the time this preliminary literature review was conducted in 2011, only a few studies were identified that came close to identifying interventions that are nursing practice generated. For example, Jackson and Stevenson (2000) aimed to describe, by consulting with psychiatric practitioners of different disciplines in the United Kingdom, what core nursing activity was needed for people in contact with mental health services. A qualitative, grounded theory methodology was selected to examine effective and ineffective nursing interventions in relation to specific client needs. They concluded that:

Nurses are the most flexible and accessible workforce available to clients to bridge the gap between intimate and professional knowledge and, in so doing, cement mental health services together... How nurses are able to anticipate, or second-guess, how patients want them to be is worthy of further research (p. 386).

Happell, Palmer and Tennent (2011), in describing the work of mental health nurses in the Mental Health Nurse Incentive Program (MHNIP) in Australia, provide a significant contribution to elucidating distinctive aspects of mental health nursing in this context. They concluded that 'future research and evaluation activities can contribute to a developing understanding of how these roles can enhance a more responsive mental health service system' (p. 337).

Similarly, Hurley's (2009a, 2009b) studies previously referred to, explicate distinctive aspects of mental health nursing in achieving therapeutic outcomes for clients particularly in relation to talking therapies.

#### **2.2.5.2 A biomedical focus is too limiting**

Much of the literature related to mental health nursing interventions, outcomes and scope of practice tend to be bio-medically focused (Hyde et al. 2006). While some studies allude to nursing intervention as a distinct contributing factor, none defines the distinctive nursing nature of this intervention and most are inconclusive in terms of outcomes and call for more research in this area (Cullum et al. 2007; Happell et al. 2009; Huxley et al. 2003; Manna 2010; Redhead et al. 2011; Weaver et al. 1999; Yakimo, Kurlowicz & Murray 2004; Zolnierrek 2009).

#### **2.2.5.3 A model of mental health nursing based on its practice is needed**

Most studies call for more research defining the nursing characteristics of its practice. Specifically in relation to nurse decision-making, one commentator claims that there is a need for a model that makes sense of the informal theory that is generated through practice (Crook 2001).

Exploring the practice in which mental health nurses engage in order to improve client outcomes, as aimed in this research study, may help define the range of roles and activities that are based on distinct nursing knowledge, attitude, skill, training

and experience. This also resonates with Crook's (2001) conclusions that it is increasingly evident that both theoretical knowledge and experience contribute to mental health nursing expertise where he warns:

As a profession we stand at risk of being accused of using trial and error to inform our practice unless we take the time to explore, analyse and describe the nature of that knowing (p. 4).

## **2.3 The potential significance of this study on mental health nursing in Australia**

This and the previous chapter have outlined the motivation for pursuing such a study, its significance in the Australian context of mental health nursing practice, and new knowledge to explore in relation to its areas of interest. The essence of this research study, as examined in the preliminary literature review, is the exploration of characteristics of mental health nursing hitherto either not or under-explored. The intent is the development of a theoretical model that will add substantive new knowledge and understanding of the discipline of mental health nursing in a contemporary context.

It is also anticipated that a theoretical model of nursing, generated from practice by specialist mental health nurses working in an autonomous way, will be authoritative in terms of legitimatising its identity and scope of practice within a distinct nursing paradigm.

Pursuing a qualitative study adds weight to the importance of exploring practice, in a substantive way, where definitive models of the essence of mental health nursing are lacking. Much of the literature related to mental health nursing in Australia is descriptive in nature. A grounded theory methodology has been chosen to go beyond description towards conceptual and theoretical development of mental health nursing practice. A quantitative study, for example, comparing mental health nursing practice against other disciplines, would not achieve this purpose. It would provide descriptions of differences of practice between disciplines rather than generating, as this study strives to do, a model of practice that is developed from nursing practice alone. In order to understand and develop theory surrounding mental health nursing, clear analysis of its qualitative aspects is critical.

The contemporary climate of health care is also one where paradigms of health care provision are changing. Johnson and Paton (2007) propose that health services need reform from a reactive approach to illness, to one of prevention and health promotion, and to move from a medical paradigm to one of social and environmental determinants. Nursing, because of its broad base of education based on the sciences and its art encompassing holistic care, is well placed to coordinate health care in the context of these various determinants. The voice of nursing, as a discipline with a distinct orientation to care and service provision, needs to be heard and acknowledged in the development and growth of services.

In support of this notion, Ham (2003) proposes leadership and organisational development is required to build the capacity for change and innovation in both individuals and the organisation with a common goal of improvement in client care. He supports engaging professionals in the reform process as they have a large degree of control in such organisations. Ancona et al (2007) propose, for a modern world, a model of distributed leadership. Parry (1996, pp. 26-27) asserts that 'transformational' leadership is required for reform. He purports transformations include a shift from stability to enthusiasm for challenge, change, and progress, group interest overriding self-interest and compliance giving way to willingness. Graber and Kilpatrick (2008) reinforce transformation that is based on shared organisational and individual values which, by implication, should give voice to all those involved in the business of the organisation.

This research study was generated out of an enduring identity debate within the mental health nursing community and relates closely to the position, status, role and professionalism of mental health nursing. Exploring the distinctive nature of the contribution of mental health nursing, it is argued, provides a platform for asserting a rightful and proper place of mental health nursing, as a specialist discipline, in the health care context in Australia. Acknowledging the distinct contribution by nursing to positive client outcomes has the potential for raising the profile and voice of mental health nurses in a contemporary and changing environment. This has implications for the mental health workforce beyond industrial and supply concerns and a potential to better influence policy development in relation to mental health.



## **2.4 Questions for inquiry related to the area of interest in this study**

At one level, this research study aims to explore what mental health nurses do, what interventions they engage in their practice, and what positive client outcomes result from this practice. At another level, it attempts to elucidate what is distinctive or special about this practice; defining whether there is something special about mental health nursing that may not be shared by other disciplines that have not had nursing training and experience.

Specifically, as outlined in the preceding sections, its objectives are to:

1. Explicate the essence and nature of mental health nursing and its scope in a contemporary context;
2. Identify the particular contribution of mental health nursing in the context of its impact on improving client care and outcomes;
3. Justify the claim that specialist education and training in mental health nursing should be the minimum standard for an adequate workforce;
4. Add to the positive identity of mental health nursing by facilitating an understanding of it as a professional discipline by others; and
5. Provide an explanation of distinctive mental health nursing practice irrespective of the practice setting in which it occurs.

Addressing these challenges raised a number of questions which formed the basis of inquiry with participants, and other sources of data such as the literature.

Specifically, the initial questions pursued were:

1. How do mental health nurses define or describe their practice in terms of its distinctiveness and within what boundaries?
2. What are the philosophies of care and/or values to which mental health nurses adhere that may distinguish them from other disciplines?
3. Are there practices and interventions that can be or are performed only by mental health nurses?
4. Of the interventions used by mental health nurses, does a nursing perspective define a distinctive practice in the execution of these interventions?

5. How do mental health nurses identify and determine positive outcomes for their clients?
6. What is the perception of the care, provided by mental health nurses, from clients, families and/or other health professionals?

The above questions provided the basis for initial data collection from participants as a starting point in the research process.

# Chapter 3

## ***Methodology***

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When undertaking research, the choice of methodology is a key component. While this may seem a straightforward quest, the choice can be made more complex depending on a number of factors. One of these factors is what methodology can best explore the phenomena of interest. If the methodology is undergoing its own change and reform, then this process is further complicated.

Nevertheless, decisions have to be made by the researcher what methodological model will be adhered to as the philosophical underpinnings and process of inquiry and analysis is determined by the model chosen. Consequently, this affects the manner in which the research is undertaken.

In this chapter, some of the key considerations in choosing a grounded theory methodology, and the opportunities they provide for the present research study, are explored. A literature review is used to discuss the fundamental tenets of grounded theory and its distinguishing features, its methodology and the manner in which this has been interpreted by various commentators, and how it is applied in this research study. It concludes with a chosen path forward that best fits, it is argued, the issues of interest in this study.

### **3.1 Grounded theory epistemology**

Grounded theory epistemology has evolved from a basis of interactionist theory and symbolic interactionism. Interactionism was expounded by Charles Cooley, regarded as one of the founders of sociology, in the early 1900s (Broom & Selznick 1973). Interactionism attempts to understand the process of action between individuals. It starts with the assumption that action is meaningful for those involved and these meanings are open to interpretation and develop, modify and change within the actual process of interaction (Haralambos & Heald 1980). Cooley also posited that people's reactions and feedback to each other develops their sense of self through these interpersonal relations, therefore the 'self' being a social construction as well as a personal reality, which he called the 'reflected or looking glass self' (Broom, Selznick & Darroch 1981, p. 98).

In sympathy with this philosophy evolved the tradition of the Chicago Interactionism and Philosophy of Pragmatism in the work of George Mead and John Dewey. According to Corbin and Strauss (2008), Mead purported that knowledge arises through the acting and interacting of self-reflective beings. He was also interested in this process, its social context and the inevitable influence of culture. Haralambos and Heald (1980) purport that from the work of Dewey and Mead, the philosophy of 'symbolic interactionism' was developed and was given expression by a student of Mead's, Herbert Blumer who systematically developed Mead's ideas in the 1960s. He put forward that symbolic interactionism was based on three premises. Firstly, rather than merely reacting to external or internal stimuli, people act on the basis of the meanings they ascribe to others' actions. Secondly, meanings are not fixed or preformed, but are created, modified, developed and changed within and through interactions. And thirdly, meanings are the result of complex interpretive procedures employed by the actors within an interactive context.

Grounded theory was initially developed by the sociologists Glaser and Strauss in the mid to late 1960s. According to Stern, Allen and Moxley (1984), Glaser and Strauss were recruited as professors into the newly established doctoral program at the University of California, San Francisco (UCSF) to help guide nurses in their research. In the course of their own research, they developed a new approach they called grounded theory, a qualitative approach which ...

... seemed to them to bring together two worlds of research, qualitative and quantitative, in such a way that a clear representation of reality could not be gained through the use of either method alone ... By fusing quality and quantity, a methodology emerged that offers distinct advantages for the researcher interested in finding natural solutions to problems under study. By retaining theory building techniques that call for continual re-designing of the analysis, the method allows for the creative flow of ideas ... and the technique of constant comparison of incoming data as conceptualisation develops, the method assures that the emerging theory is grounded in the study rather than being forcibly related to some grand theory that simply does not fit (pp. 371-373).

Glaser and Strauss for the first time introduced procedures and methods for qualitative research that guided the development of 'substantive theories from data at a time when the dominant method of producing knowledge was by testing theories' (Parahoo 2009, p. 4).

In defence of grounded theory and in writing strategies for their research method, Glaser and Strauss (1967) constantly reinforce that the focus of their approach is 'the discovery of theory from data systematically obtained from social research' which they assert should help ensure the theory will fit and work and ...

... enable prediction and explanation of behaviour, be useful in theoretical advance in sociology, be usable in practical applications, provide a perspective on behaviour, and guide and provide a style for research on particular areas of behaviour (pp. 2-3).

From this emerges distinguishing features which differentiate grounded theory from other methodologies and approaches to qualitative research.

As expounded by Strauss and Corbin (1994), grounded theory does social research, assuring that some sort of social science is possible and desirable. Sources of data are the same as other qualitative research, that is, interviews, field observations and all levels of documents, and the analysis of data is interpretative. Interpretations, though, are sought for 'understanding the actions of individuals or collective actors being studied' and 'must include the perspectives and voices of the people' being studied, reminiscent of its roots in symbolic interactionism. Grounded theorists share with other qualitative researchers the acceptance of responsibility for their interpretative roles. Strauss and Corbin (1994, p. 274) further purport that it is not sufficient 'merely to report or give voice to the viewpoints of the people, groups, or organisations studied' but to go beyond this toward conceptual abstraction and theory generation.

### **3.2 The rationale for choosing grounded theory for this study**

It has been argued that qualitative research methodology provides the best fit for this research study. The most fundamental characteristic of qualitative research is, according to Bryman (1988) ...

... its express commitment to viewing events, action, norms, and values from the perspective of the people being studied and is ... an approach to the study of the social world which seeks to describe and analyse the culture and behaviour of humans and their groups from the point of view of those being studied (p. 48).

In common with other methodologies, this study's qualitative nature seeks to include and use the voice of mental health nurses as well as their clients and other care givers. Qualitative methodologies, however, differ. Creswell (2013) depicts the different foci of five approaches to qualitative inquiry which reinforces how grounded theory differs significantly from other methodologies for its focus on generating theory. Grounded theory was a deliberate choice for this research study for the following reasons.

Firstly, the purpose of the research is to develop a theoretical model of mental health nursing practice that helps define its distinctive contribution to mental health care and service delivery. While other methodologies may add to the description of the nature, scope and consequences of mental health nursing, grounded theory goes beyond this to develop concepts and theory around the phenomena of interest; in the case of this researcher's study, what is mental health nursing and how does this contribute to positive client outcomes in a way that is distinctive or special.

Strauss and Corbin (1994) refer to grounded theory as ...

... a general methodology for developing theory that is grounded in data systematically gathered and analysed. Theory evolves during actual research and it does this through continuous interplay between analysis and data collection (p. 273).

Walker and Avant (2011) define, in generic terms, a theory as ...

... an internally consistent group of relational statements (concepts, definitions and propositions) that presents a systemic view about a phenomenon and which is useful for description, explanation, prediction and control ... constructed to express a new idea or a new insight into the nature of a phenomenon of interest ... by virtue of its predictive potential, is the primary means of meeting the goals of the nursing profession concerned with a clearly defined body of knowledge (pp. 60-61).

It is acknowledged that there is a debate among grounded theorists about what constitutes legitimate theory development based on beliefs and values from both positivist and interpretative definitions (Birks & Mills 2011; Charmaz 2006). However, agreement is reached with the emphasis on conceptualisation which distinguishes grounded theory from descriptive methods. According to Parse, Coyne and Smith (1985), the descriptive method of research is a human science method which focuses on discovering the meaning of an event in time and generates hypotheses for further research and enhances theory. Strauss and Corbin (1990) claim that description per se means there is little interpretation of data and makes no attempt to relate themes to form a conceptual scheme. In contrast, grounded theory method of research places similar data into groups and gives these conceptual labels, which necessitates placing interpretations on the data. Theory development uses concepts by making statements about relationships between concepts.

It is posited, therefore, that theory development adds a higher level of intellectual consideration and consequent discourse about mental health nursing. This approach is compatible with the present study for the intent is to go beyond description of the phenomena of interest, and theory generation provides this aspirational goal. Grounded theory advances the dialogue, it is asserted, to a level that can explore educational, practice and research issues more decisively using the theoretical position developed. It is further argued that this level of contribution is significantly richer.

Secondly, it is well suited to and popular in studying nursing phenomena. While grounded theory is not without its critics, it does, according to Stern and Porr (2011), remain a popular qualitative methodology in the area of health sciences and nursing. In her earlier writings, Stern and her colleagues (1984) asserted that the process of nursing and grounded theory research methodology are linked by the fact that the process of nursing occurs in a natural rather than a controlled setting which they purport is similar to the process of grounded theory in that 'nursing process involves a constant comparison of collected and coded data, hypothesis generation, use of the literature as data, and collection of additional data to verify or reject hypotheses' (pp. 371-374).

This notion fits well with the context of this study where the mental health nurses participating are interviewed at their place of work, about their practice in which they engage, and its outcomes.

### **3.2.1 The place of Symbolic Interactionism**

Grounded theory is concerned with social and psycho-social processes and underpinned by interpreting and attaching meaning to interactions of the actors involved. Support is reinforced for a methodology with its philosophical underpinnings of symbolic interactionism by several authors (Aldiabat & Le Navenec 2011; Gardner 2010; Gardner, McCutcheon & Fedoruk 2010; Jeon 2004). Of particular relevance is Jeon's (2004) grounded theory study that argues strongly in favour of the relevance of symbolic interactionism in her examination of mental health nursing practice in an aged care setting. She asserts that ...

... the symbolic interactionistic perspective provides the researcher with a guiding framework to explore how community nurses define the family caregivers' situation, and vice versa. Therefore, the task of the study is to discover what is going on in the processes through which the community psychiatric nurses work (p. 251).

Also, Aldiabat and Navenec (2011) argue that grounded theory methodology and symbolic interactionism are compatible in both their goals and assumptions and need to be well understood by researchers. They further assert that this combination is also effective in qualitative human behaviour research because:

- (a) Symbolic Interactionism provides a guiding framework to collect data about the meaning of a particular type of behaviour and the contextual sources of such meanings, and how they change in and through social and physical time and space; and
- (b) Grounded Theory methodology affords a systematic approach to generate a theory that illuminates human behaviour as a social process among actors in their interactional context (p. 1068).

Their argument for compatibility of grounded theory and symbolic interactionism is further supported by reference to the world being examined as one of 'shared symbolic meanings' between the actors. This is in a context where 'the researcher



and research participants are assumed to be interactively linked in a mutual relationship in the natural field to investigate their behaviour'. They posit that 'human beings and shared meanings of reality can be defined only through interaction between and among the researcher and participants in the context of the phenomena of interest' (p. 1068). They reinforce their argument by positively correlating assumptions of symbolic interactionism from various authors with assumptions of grounded theory espoused by Strauss and Corbin (p. 1070).

Breckinridge, Jones and Nicol (2012) support a Glaserian view that grounded theory is a 'a general method, which can use any type of data and is not attached to any one theoretical perspective; it is essentially ontologically and epistemologically neutral' (p. 5). Newman (2008), too, supporting a Glaserian approach to grounded theory, challenges the use of symbolic interactionism as a theoretical perspective for her study. She relies on Glaser's refutation of needing any theoretical perspective to guide data analysis. In using a Glaserian approach, she claims that symbolic interactionism is not the foundation of grounded theory and strict adherence to its tenets stultifies biases and stifles the analysis process. She says it ...

... imposes a straightjacket of conformity when interpreting emerging concepts and does not lend itself to the freedom of discovery in the inductive process that is required by conventions of constant comparison method ... and ... closes the researcher down to being open to the full range of theoretical codes that can or may emerge during analysis (p. 106).

Milliken and Schreiber (2012) take the opposing view that ...

... in spite of Glaser's assertion to the contrary ... using symbolic interactionism is not the same as applying a philosophy or theory that limits the range of theoretical coding by imposing a set of predetermined concepts on a data set (p. 685).

They assert that it in fact provides the researcher 'with a set of sensitizing concepts' which expands 'the breadth of theoretical codes available' and posit that grounded theory is 'inherently symbolic interactionist in nature' and cannot be divorced from it (p. 687).

They warn that researchers need to pay attention to the centrality of interaction in the research process rather than viewing grounded theory solely as a data analysis

technique. Their conclusion is that 'it is impossible to develop fully grounded and contextualized theories that explain human experience ... without attending to the ontological and epistemological underpinnings of the method'. Their argument is that ...

... locating the research methodology within symbolic interactionism provides a means for investigation not only of the social world but also of the contextualized processes by which human beings construct and engage with their social worlds (pp. 686-687).

This is reinforced by Aldiabat and Navenec's (2011, p. 1077) argument that the compatibility and fit between grounded theory and symbolic interactionism assumptions and concepts 'helps researchers in nursing and other fields know how to collect and analyze data regarding human behaviour'.

Stern and Porr (2011) note that Strauss, as a student of Mead under Blumer's mentorship, coupled symbolic interactionism with pragmatism which, they claim, 'served as key drivers to the internal workings of grounded theory and enabled Strauss and Glaser to methodologically account for human action in the context of problematic situations' (pp. 29-30). Similarly, Hammersley (2010, p. 87), in examining Blumer's methodology and its relevance to contemporary research, proposes that his methods of comparing analytical elements with each other mirrors what Glaser and Strauss referred to as 'the constant comparative method'.

These philosophical foundations are important notions for this study where the focus of interest is mental health nurses and their interactions with those they serve and the positive outcomes as a result of them. It is proposed that these concerns reflect Blumer's three premises of symbolic interactionism.

Firstly, the relationship between mental health nurses and their clients involves and requires a therapeutic alliance which is generated by the meanings each party ascribes to the value of that relationship for them. This mutual engagement, which is judged by each party by their behaviour and/or action to each other, is in sync with Blumer's proposition that people act on the basis of the meanings they ascribe to others' actions.

Secondly, the meanings generated become a therapeutic intervention as a result of these interactions. This reinforces Blumer's notion that meanings are not fixed or

performed, but are created, modified, developed and changed within and through interactions.

And thirdly, each of the parties utilise interpretative procedures to generate, modify and develop meanings through these interactions, which Blumer describes as meanings resulting from complex interpretive procedures employed by the actors within an interactive context.

Another dimension adhering to this philosophical notion is the interaction between the researcher and participants. The interactive nature of this relationship, and the consequences of this relationship in terms of analysis and interpretation of data, will be explored later in this chapter.

For all of the foregoing reasons, it is asserted that the interactive processes occurring in this research study fits well with the philosophy of symbolic interactionism.

### **3.2.2 Addressing credibility and rigour**

There is discourse in the literature about the variety of applications of grounded theory, sometimes casting doubt on whether some studies can indeed authoritatively bear the label of grounded theory (Amsteus 2014; Breckenridge, Jones & Nicol 2012; Cutcliffe 2000, 2005; Hunter et al. 2011a, 2011b; Moore 2009, 2010; Newman 2008).

There has also been much discussion in the literature over the last three decades about ways by which a grounded theory can substantiate its rigour, credibility and applicability. Stern et al (1984) assert that much social psychological research, using in-depth interviews and participant observation to collect often large and complex data, lacks an organised procedure for the analysis of data. While such analyses yield important insights into human behaviour, they claim that 'carelessly coded or completely uncoded data allows the investigators to embark on logical excursions resulting in conclusions that border on the philosophical', a major drawback in that 'this kind of theory building leads to loosely defined concepts'. In contrast, they propose grounded theory utilises unique systematic methods of data analysis, where each piece of datum is continually compared with and against the others through coding techniques (p. 374).

Baker, Wuest and Stern (1992, p. 1359) suggest that credibility for existing qualitative methods will only be established if nurse researchers explicitly describe their data collection and analysis procedures. However, Baker, Wuest and Stern (1992), warn that there is 'a tendency for nurses to blur distinctions between the various qualitative approaches and to combine their methodological prescriptions eclectically'. They reinforce that 'qualitative data collection procedures should be explicit and consistent with the underlying assumptions of the specific approach selected' (p. 1355).

Morse (1991) cautions grounded theorists following too rigid a protocol for data collection and analysis. She asserts that 'the re-interviewing of subjects at different times and places tends to eliminate any random errors that might occur in both investigator and subject/informant performance' (p. 180). Similarly, Stern (1985, p. 151) confirms this notion of reliability in grounded theory because its method 'tests and re-tests hypotheses by asking participants if what was true for other participants is true for them'. In terms of validity, she claims that because the theory is derived from the data, it must be valid and it must look at the problem at hand, and that the context of the research defines its predictability by purporting that ...

... once one has discovered such a process in a substantive area, the identified process can be transferred to other contexts to predict what will happen there. In this way, a grounded theory can be thought of as one that is predictive (p. 151).

Cutcliffe (2005) argues that the way in which credibility of a grounded theory is established has been well documented in the literature. In accord with Glaser and Strauss (1967, p. 237) and Strauss and Corbin (1990, p. 23), he states that, in order for a grounded theory to have practical application, it needs to have four highly inter-related properties. Firstly, it needs to have 'fit', being faithful to the everyday reality of the substantive area and carefully induced from diverse data. Secondly, the theory needs to be comprehensible to the participants of the research thereby having 'understanding'. Thirdly, because interpretations are conceptual and broad, the theory is abstract enough and sufficiently variable to apply to a variety of contexts and as a consequence has 'generality'. And fourthly, the theory must enable the

person using it to have enough 'control' in everyday situations to make its application worth trying (p. 425).

In a more recent article on methodological precision in qualitative research, Cutcliffe and Harder (2012) modify these criteria in line with Glaser's evolution of ideas in relation to grounded theory. 'A well-constructed grounded theory', they purport, 'will meet its four most central criteria: fit, work, relevance, and modifiability' (pp. 6-7).

It appears that nothing is static and such refinement and evolution of ideas, it can be argued, enhance rather than dilute the understanding and contemporary application of established research methodologies. Nevertheless, the established credibility of grounded theory is not shared by all commentators. While acknowledging its sustained popularity, Thomas and James (2006) challenge the notions of 'theory', 'ground' and 'discovery' in grounded theory procedures and warn educational researchers to be wary. They argue that these notions ...

... constrain and distort qualitative inquiry, and that what is contrived is not in fact theory in any meaningful sense, that 'ground' is a misnomer when talking about interpretation and that what ultimately materializes following grounded theory procedures is less like discovery and more akin to invention (p. 767).

While they agree that grounded theory's systematic analysis of data originally devised by Glaser and Strauss was a major contribution to making qualitative inquiry legitimate, they view this exercise as now anachronistic. They imply this is akin to pseudo-science<sup>7</sup> that diminishes the narrative of both the participant and the discussant in the research exercise and thereby losing the 'best of qualitative inquiry' and are dismissive of the need to continually reinvent grounded theory (pp. 790-791).

Contrary to the view that grounded theory method is outdated, the premise in this thesis is that exploring critique around issues of rigour, credibility and integrity of grounded theory method is evolutionary and productive in contemporising the method.

Birks and Mills (2011, p. 149) summarise the classic approaches for judging grounded theory research and report on three iterations by Glaser over 25 years, three by Strauss and Corbin over 18 years and one by Charmaz in 2006. While there

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<sup>7</sup> The term 'pseudo-science' is my terminology, not that of Thomas and James.

is conflict of opinion between such commentators, the discourse has challenged researchers to defend their position on a chosen methodology and method and, as suggested by Cutcliffe (2000) ...

... the interests of researchers might be served by attention to issues of precision including, avoiding method slurring, ensuring theoretical coding occurs, and using predominantly one method of grounded theory while explaining and describing any deviation away from this chosen method. Such mindfulness and the resulting methodological rigour is likely to increase the overall quality of the inquiry and enhance the credibility of the findings (p. 1476).

### **3.2.3 Evaluating research quality**

Chiovitti and Piran (2003, pp. 427-430), in relation to their own study on what mental health nurses saw as the meaning of caring for patients in hospitals, developed eight methods of research practice used to enhance rigour in the course of conducting a grounded theory research study. These standards of research rigour were framed around Beck's (1993) criteria of 'credibility', 'fittingness', and 'auditability' developed to facilitate the critique of qualitative research. Beck (2009, pp. 544-547) later developed more detailed criteria for critiquing qualitative research across the domains of 'credibility', 'dependability', 'confirmability', 'transferability' and 'authenticity'.

In a literature review exploring ways to enhance and demonstrate rigour in a grounded theory study, Cooney (2011, pp. 21-22), also using Beck's schema, developed criteria for 'credibility', 'auditability' and 'fittingness'. Charmaz (2006, pp. 182-183) uses the four domains of 'credibility', 'originality', 'resonance' and 'usefulness' as criteria for evaluation grounded theory studies. And Birks and Mills (2011, pp. 153-154) put forward specific criteria for evaluating grounded theory research against the broader three domains of 'researcher expertise', 'methodological congruence' and 'procedural precision'.

From these varying criteria, a composite set of criteria against ten derived domains for self-evaluation purposes in this research study, has been developed. These and the sources used to create them are detailed in Appendix 2. This composite set of

criteria has provided a personal guide to prospectively and retrospectively address issues of rigour and credibility throughout the research process. An evaluation of the research process using these criteria is outlined in Chapter 7 of this thesis.

As a relative novice in grounded theory research, these process and procedural aspects were relatively easy to digest and adopt. The further challenge posed was coming to a firm position about what type of grounded theory was the best fit with the area of research interest.

### **3.3 What type of grounded theory? The grounded theory debate**

As previously argued, the purpose of grounded theory is to do social research and generate theory. There is, and has been, much debate about different models of grounded theory, differentiating between what has become known as ‘classic’ grounded theory and more recent postmodern iterations. These perspectives are explored and critiqued in the following sections towards a definitive position for the approach taken in this study.

#### **3.3.1 Classic or ‘Glaserian’ grounded theory**

Throughout all the literature accessed in relation to the use of grounded theory for this study, there is due acknowledgement to the foundation of this research methodology at the feet of Barney Glaser and Anselm Strauss as articulated in their seminal work “The Discovery of Grounded Theory: Strategies for Qualitative Research” (1967). The application of this original work is often referred to as classic grounded theory or Glaserian grounded theory and is associated with its positivist, objectivist underpinnings (Simmons 2011, p. 15). Glaser and Strauss developed the systematic approach to the study of interactions, known as ‘grounded theory method’, to bridge a perceived gap between theory and research and the consequent undervaluing of qualitative studies (Lo-Biondo-Wood & Haber 1994, p. 265).

Glaser is often defended as the rightful original claimant to the name and identity of grounded theory that sticks firmly to the method developed in the 1960s. Glaser’s co-founder, Strauss, along with Corbin, later developed specific procedures in support of

the methodology but were vehemently criticised by Glaser (1992) for being overly prescriptive which he claimed worked against theory being discovered from the data, a venerated tenet of grounded theory according to Glaser. He acknowledges the positivist influence in grounded theory and in support of the rigour and comprehensive methods engaged in its development, he criticises Strauss's subsequent work by emphasising that it is ...

... vital to note that the fundamentals of Grounded Theory, the underlying analytic methodology, are in very large measure drawn from the analytic methodology and procedures of inductive quantitative analysis discovered by researchers and students ... in the 50s and 60s" (p. 7).

In his criticism of Strauss' 1988 book "Basics of Qualitative Research", Glaser (1992, p. 5) describes the book as 'bordering on immorality', the basis of his criticism resting on the thesis that rather than theory emerging from the data, Strauss forces conceptual description which he claims is not grounded theory.

Simmons (2011), in support of Glaser's stance, argues that grounded theory as articulated in Glaser and Strauss' 1967 work ...

... produces theory that is more completely grounded in data, which makes it more suitable for action. In classic grounded theory, throughout the process, everything must "earn" its way into a theory through constant comparison of data rather than being imported from other sources (p. 17).

In the face of two dominant schools of grounded theory emerging, namely that of Glaser and that of Strauss, Morse (2001) argues that grounded theory cannot be labelled as such unless it adheres to its distinct style and form. She lists these as:

- a) it uses gerunds (a noun formed from a verb, describing an action, state, or process) indicating action and change; grounded theory focuses on a process and trajectory, resulting in identifiable stages and phases;
- b) categories identified in the data are developed as concepts and then linked as a trajectory;
- c) it has a core category, discovered through the process of analysis and the strategies and techniques of coding, categorising and re-categorising, and a basic psycho-social process that ties stages and phases of the theory; and



- d) it is abstract but unique in that it makes the synthesis of descriptive data readily apparent through its concepts and relational statements (pp. 1-5).

### **3.3.2 Postmodern developments**

The debate has continued and the methodology has evolved. The postmodern era challenged the notions of Glaser's position on grounded theory as there was a more substantial shift from positivist research to de-constructed and re-constructed concepts of social phenomena.

In later iterations of grounded theory, Strauss, in concert with Corbin, drew more on postmodern philosophical models which Corbin (Corbin & Strauss 2008) re-emphasised in her publication after Strauss's death. Corbin struggles with her position which claims an evolved version from Strauss's model. She declares her own evolution in the application of grounded theory was influenced by postmodernist and feminist writings. While acknowledging that grounded theory is a specific methodology developed by Glaser and Strauss, Corbin uses the term in a more generic sense 'to denote theoretical constructs derived from qualitative data'. She proposes that knowledge is not merely discovered but constructed through the research process and states that ...

... concepts and theories are constructed by researchers out of stories that are constructed by research participants who are trying to explain and make sense of their experiences and/or lives both to the researcher and to themselves (pp. 9-10).

The most dominant challenge in more recent times to classical or 'Glaserian' grounded theory is that expounded by Charmaz (2006) who definitively asserts a model of grounded theory rooted in the philosophy of constructivism. This, in simple terms, proposes that theory generation is not discovered in the data, but rather is a co-construction between researcher and participants where the voice and meaning of the participants' contribution is emphasised. It is based on interpretive definitions of theory that are abstract and rest on the theorist's interpretation of the studied phenomena rather than on reductionist explanations of positivist theoretical dispositions. It is also fully compatible with symbolic interactionism, asserts Charmaz, by engaging in the process of the researcher interpreting participants'

meanings and actions, while at the same time participants interpret those of the researcher. Within this process, 'rather than explaining reality, social constructionists see multiple realities and therefore ask: What do people assume to be real? How do they construct and act on their view of reality?' (Charmaz 2006, pp. 126-127).

Charmaz (2006) pays due respect to the founding of grounded theory to Glaser and Strauss and the enormous impact it has had on promoting and profiling qualitative research as 'proper' and legitimate research in the face of positivist dominance. She acknowledges its philosophical basis of symbolic interactionism as a potent and important influence but disagrees with some basic assumptions about theory development. She asserts that, in the classic grounded theory sense, 'Glaser and Strauss talk about discovering theory as emerging from the data separate from the scientific observer' (pp. 4-8). In contrast, she purports that 'neither data nor theories are discovered' but rather are 'part of the world we study and the data we collect'. She clarifies this point further by asserting that grounded theories are constructed 'through our past and present involvements and interactions with people, perspectives, and research practices' (p. 10).

The model unashamedly declares a diversion from Glaserian grounded theory and asserts that it brings grounded theory into the 21st century. Ironically, Charmaz (2006) argues that while Glaser and Strauss fought the dominance of positivistic quantitative research, that by 1990, grounded theory became known for both its rigour and usefulness and its positivist assumptions. However, she states that a growing number of scholars have moved away from the positivism in both Glaser and Strauss and Corbin's version of the method and asserts basic grounded theory guidelines can be used with 'twenty-first century methodological assumptions and approaches' (p. 9). Charmaz (2009, p. 128) views grounded theory not as a 'unitary method, but as a useful nodal point around which researchers discuss contemporary debates in qualitative inquiry'.

### **3.3.3 Common ground**

In relation to how grounded theory has been applied, Cutcliffe (2000) claims, in his examination of studies purporting to be based on grounded theory, that in many cases each study bears little resemblance to each other in terms of their methodological claims. He draws on the tenets of grounded theory expounded by

Glaser and calls for a distinction between this and other evolved models of grounded theory. In particular, Cutcliffe draws attention to the centrality of 'conceptualisation' as the core of grounded theory and puts forward the proposition that the resultant theory is undeveloped if it does not explain the social or psycho-social organisation of the people it is studying. Failing in this endeavour moves 'the methodology beyond the limits or boundaries' and produces 'some method that should not be regarded as grounded theory' (pp. 422-426). Where such discrepancies occur, he argues that 'it is necessary to distinguish such methods from 'pure' Glaserian grounded theory, and 'describe the resulting method as 'modified' grounded theory', while acknowledging the methodological adaptations that have taken place with the evolution of the method' (p. 421).

In an attempt to assess whether such divergence dilutes the essence of grounded theory method, Amsteus (2014) undertook a comprehensive evaluation of grounded theory authors and a critical appraisal of its underlying philosophies. He concluded that divergent grounded theory can be considered valid, conditional on being clear about the kind and extent of testing that was undertaken in a study as a priority rather than adherence to specific rules or procedures.

Hunter et al (2011a, p. 6), compare grounded theory approaches based on Glaserian, Straussian and Constructivist orientations. They conclude that while all 'offer a structured, rigorous methodology ... researchers need to understand their choices and make those choices based on a range of methodological and personal factors'.

Common components of grounded research method are evident in these examples as is the evolution of thinking about the method. In the words of Birks and Mills (2011, p. 3), 'Few things are ever black and white, especially when it comes to research with an overtly interpretive component, and there is much to be learned from all antecedent grounded theorists'. Nevertheless, commentators agree that there are basic processes that distinguish grounded theory from other methodologies and these need to be adhered to in order to call it grounded theory by whatever other variation in philosophy.

A schema for data analysis used in this study is outlined in the following chapter and includes agreed basic processes. For this research study, a constructivist model of

grounded theory has been chosen as one which, it is argued, is the best fit for the phenomena of interest being researched.

### **3.4 Constructivist grounded theory: Ontological determinants**

In reviewing the literature on grounded theory, positions in support of classical or 'Glaserian' grounded theory were accessed (Breckenridge, Jones & Nicol 2012; Hunter et al. 2011a, 2011b; Kertchok, Yunibhand & Chaiyawat 2011; Moore 2009, 2010; Newman 2008). Literature that supported constructivist approaches was also reviewed (Aldiabat & Le Navenec 2011; Birks, Chapman & Francis 2006a, 2006b; Birks & Mills 2011; Gardner, McCutcheon & Fedoruk 2010; Ghezeljeh & Emami 2009; Licqurish & Seibold 2011; McGeorge 2011; Mills, Bonner & Francis 2006a, 2006b; Mills et al. 2007; Mills, Francis & Bonner 2007; Snowden & Martin 2011).

While the debate and conflict between these approaches is acknowledged, my own values and beliefs also required consideration in order to apply a faithful dedication to the research process. Birks and Mills (2011) support ontological determinants of methodological choice and say that:

Interrogating your own philosophical position requires thinking through what you believe to be true about the nature of reality. Once you have made a decision about where you are ontologically, you need to examine your beliefs about how researchers can legitimately gain knowledge about the world (p. 51).

Further, Urquhart et al (2010, pp. 360-361) reinforce that 'a researcher's own ontological and epistemological position will impact on their coding and analysis of the data and the way in which they use grounded theory'.

The position I have taken for this study was one that acknowledged the basic tenets of grounded theory as originally espoused, with due attention to a changing world conceptually and technologically that inevitably influences ontological thinking. In particular, the attraction of grounded theory for this research was because it generated theory from the lived experience of those participating in the social phenomena being explored. In sync with Glaser's notion of 'emergence', I was committed to formulate concepts from the participants and other sources consulted in

relation to the phenomena of interest and formulate hypotheses to enhance knowledge, understanding and inquisitiveness about them.

Mills, Bonner and Francis (2006b) assert that 'epistemologically, constructivism emphasizes the subjective interrelationship between the researcher and participant, and the co-construction of meaning'. They also propose that constructivist researchers adopt a relativist position which adheres to the notion that the world consists of 'multiple individual realities influenced by context' (p. 2). It is this journey of exploration and discovery that I find exciting in this study, rather than a quest for a single truth, and as a consequence, the adoption of a constructivist approach is more compelling.

Therefore, the commitment for my research was to underpin its process of exploration with the following tenets:

1. The phenomena of interest were based on questions emerging from contemporary discourse about the nature, scope and consequences of mental health nursing and its identity as a distinct entity. They were not based on pre-conceived ideas about what mental health nursing is, as I was more genuinely engaged in the question rather than the answer;
2. The generation of the work undertaken in this study must be grounded in the data;
3. Grounded theory is a distinct methodology, to which the foundations of its methods must be maintained in order to claim that grounded theory has been undertaken.

The values and beliefs that influenced my decision are interrelated and involved the following four principles. These are discussed in more detail below.

### **3.4.1 The researcher/participant relationship is active**

One cannot divorce who they are from an active interpersonal relationship. Again Mills, Bonner and Francis (2006a) put forward that:

Ontologically relativist and epistemologically subjectivist, constructivist grounded theory reshapes the interaction between researcher and participants in the research process and in doing so brings to the fore the notion of the researcher as author (p. 6).

I was aware, as a mental health nurse over many years of practice, my perceptions of the world of mental health nursing were brought to the research. This raised consideration about my relationship with participants. Within a constructivist paradigm, the researcher is an active participant and not a detached, objective player. It is argued that my view of mental health nursing would intrude into both the participant interviews and the subsequent interpretation process that followed.

This consideration has also positively influenced other authors to adopt a constructivist approach to their research (Licqurish & Seibold 2011; McGeorge 2011). Mills, Bonner and Francis (2006a, p. 9) state that epistemologically, constructivists believe that 'during the process of narrative interaction, the researcher and participant give and take from each other', a process that is inseparable and indeed is the source of data that emerges.

They further suggest that a constructivist approach requires the following elements. Firstly, the creation of a sense of reciprocity between participants and the researcher in the co-construction of meaning that ultimately generates a theory that is grounded in the participants' and researcher's experiences. Secondly, the establishment of relationships with participants that explain power imbalances and attempt to modify these. And thirdly, clarification of the position that the author takes in the text, the relevance of biography and how one renders participants' stories into theory through writing (p. 9).

Hunter et al (2011b, p. 10) support a classic grounded theory approach and purport that 'Glaser argued that the rigorous application of constant comparison of researchers' memos, including their thoughts and interpretations, addresses the need for reflexive inclusion of self'. Similarly, Breckenridge, Jones and Nicol (2012) rely on Glaser's assertion that:

Researcher bias... is just another variable and a social product. If the researcher is exerting bias, then this is a part of the research, in which bias is a vital variable to weave into the constant comparative analysis (p. 3).

In spite of these explanations, which in themselves have merit, the notion of co-construction sat more comfortably with me in relation to this study. Researchers who are seen as objective, distant scientists who investigate their subjects did not ring true for the endeavour of this study. Rather, what had more meaning for me was

acknowledging that researchers, like the participants in their studies, are engaged in the process of inquiry, interpretation and meaning-making, all of which are seen as necessarily determined by the historical, social, and cultural context within which research takes place.

Corbin (Corbin & Strauss 2008) reinforces this in her defence of the legitimacy of interpretations in the research process preserving the fluid and dynamic nature of qualitative analysis. She asserts that:

We don't separate who we are as persons from the research and analysis we do. Therefore, we must be self-reflective about how we influence the research process and, in turn, how it influences us (pp. 11-12).

Similarly, Charmaz's (2006) approach, in grounded theory analysis toward developing theory, is that it offers an interpretive portrayal of the studied world rather than an exact picture of it. She argues that, as researchers and as part of the world we study, our grounded theories are constructed through 'our past and present involvements and interactions with people, perspectives and research practices' (p. 10).

So the position taken in this study was that, as a researcher, I was more than a passive player in the research process, and indeed, active in the construction of meaning as part of that process. Reassurance for this stand could be mediated, in terms of rigour, by coupling this position with quality processes and audit trails in order to encourage and demonstrate reflexivity and transparency about the analysis process.

### **3.4.2 Co-construction is a potent factor**

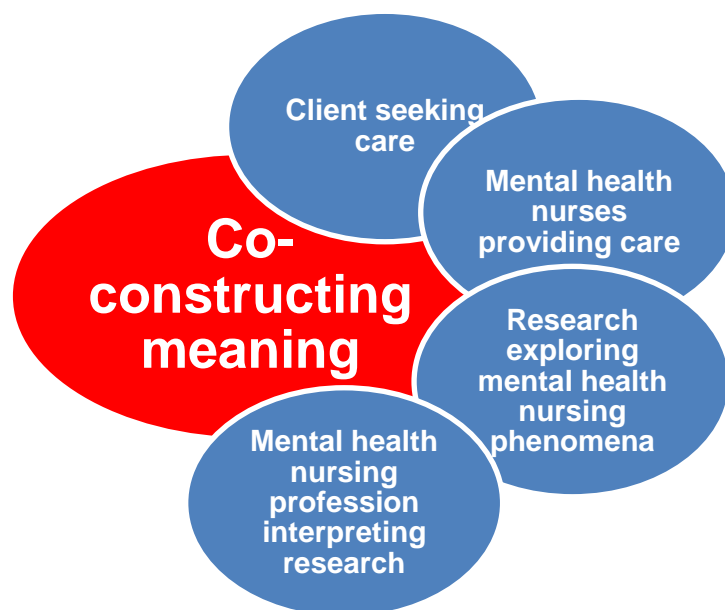
Co-construction is a potent feature of the phenomena of interest in this research study. That is, mental health nurses interviewed in the early stages of data collection seemed to be co-constructing, with their clients, interventions that were tailored to that particular social experience and interaction for an outcome that was led by the client. This process of interaction made sense and fitted with my values and experience both as the researcher and as a mental health nurse.

This phenomenon is familiar to Gardner, McCutcheon and Fedoruk (2010). In defending a constructivist grounded theory methodology for their study, they refer to

parallels of mutuality and interrelationship that a constructivist paradigm offers to nurse/client relationships. They write that:

Mental health clinicians recognise that the therapeutic encounter is based on a similar partnership and has reciprocal rewards. Whilst the intention of the relationship is for the therapist to assist the client back to wellness, there is also the potential through every therapeutic encounter for the therapist to learn more about their craft and through reflection to learn more about himself or herself as a therapist (2010, p. 261).

Further though, there appeared to be co-construction as a research process, with the research inquiry itself. This is represented graphically in Figure 2.



**Figure 2:** Co-construction as a research process

In other words, in the same way that mental health nurses co-constructed interventions and meanings with their clients, I would co-construct an interpretation of the data with participants about mental health nursing phenomena. The result of this endeavour would in turn be interpreted by the mental health professions who read the research, to construct meaning about mental health nursing identity and practice.



### **3.4.3 The research process is enhanced by reflexivity**

Self-reflection facilitates knowing oneself which in turn stimulates understanding of other phenomena. A fundamental element of grounded theory towards theory development demands, it is argued, meaningful reflective research practices in the effort to interpret social interactions.

In relation to reflexivity, Charmaz (2006, p. 131) claims that constructivists 'attempt to become aware of their pre-suppositions and to grapple with how they affect the research' which fosters, she says 'researchers' reflexivity about their own interpretations as well as those of their research participants'. This stance is put forward as a point of departure from classical grounded theory which Charmaz criticises for retaining a distant relationship with participants. Glaser's assertion that researcher bias is just another vital variable and should be revealed, accounted for and incorporated as more data for comparative analysis, also has merit (Breckenridge, Jones & Nicol 2012). This apparent conflict, however, seems to me to be a point of intersection of claims that reflect more complementary aspects rather than opposing ones.

Charmaz (2006, p. 16) also cautions grounded theorists to be aware of their background assumptions and disciplinary perspectives and their influence in shaping research topics and conceptual emphases. She draws on Blumer's notion of 'sensitising concepts'. That is, grounded theorists begin their studies with certain research interests and general concepts which generate ideas to be pursued and sensitise the research to ask particular kinds of questions about the topic.

### **3.4.4 Prominence of the participants' voice is fundamental**

Participants' views are prominent, however interpreted and explicated. Intuitively I wanted to give voice to the participants in the research. This was not an intention to always quote their words verbatim, but of doing justice to the nuances in the data they provided in the ultimate interpretation of the data towards theory development.

Acknowledging the voice of participants is a fundamental tenet of a constructivist position in data analysis. Birks and Mills (2011), gathering support from commentators such as Morse, and Charmaz and Clarke, maintain that the 'study of data in the form of recordings and transcripts exposes more about the nuances of ...

language and meanings' (p. 56). Acknowledging the constructivist approach, they contrast this to Glaser's contention that sticking to field notes (or memos) alone does justice to the data as a base for developing abstract categories from the data towards theory generation and provides the separation required by the researcher from the participants.

In relation to this research study, I identified more strongly with the constructivist position that 'interviews are not neutral context-free tools; rather they provide a site for interplay between two people that leads to data that is negotiated and contextual' (Mills, Bonner & Francis 2006a, p. 9). This also determines how you go about treating and analysing data, for example, transcribing interviews and primarily engaging in line-by-line analysis to determine initial coding that is true to the voice of the participants.

### **3.4.5 Summary**

One of the attributes of a constructivist approach is the acknowledgement of the researcher's personal involvement and impact in the research activity. Reflecting on my own values and beliefs and how this colours my world view and potentially that of the research process, was an important influence on the methodology choice for this study. It fitted well with the goal of being true to the data and the research process, while at the same time sitting comfortably with my values.

In support of the decision to apply a constructivist approach, it is asserted that constructivist grounded theory adheres to the fundamental tenets of grounded theory method in ways that preserve a credible process towards social research that generates theory.

The philosophical differences are acknowledged, however a position in favour of 'co-construction' versus 'discovery' of concepts in the data, and the relativist and subjective versus the objective nature of the researcher participant relationship, had more meaningful fit with the phenomenon of interest in this study.

Similarly, the embodiment of symbolic interactionism resonated with this study's intent and supported integrity in the process of inquiry and analysis. As such, I contend that a constructivist grounded theory approach fitted with my world view in a

way that paid due tribute to proven methods toward the aspirational goal of theory generation within a grounded theory methodology.

# Chapter 4

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## ***Methods used in this grounded theory study***

Grounded theory methodology is particularly useful for research in situations that have not been previously studied, where existing research has left major gaps, and where a new perspective might be desirable to identify areas for nursing intervention. (Schreiber & Stern 2001, p. xvii).

A distinction, however, should be made between methodology and method. Cutcliffe and Harder (2012), in espousing methodological precision in qualitative research, argue that there needs to be congruence between a method's underpinning philosophy, epistemological stances and methodological tenets. They emphasise the difference between methodology and method, albeit closely related and linked. They state that 'methodologies have been described as discourses that are comprised of epistemological views, edicts and assumptions through which scientists construct approaches (or methods) for understanding the world' (pp. 2-9).

The previous chapter explored grounded theory methodology and the adoption of a constructivist paradigm within that methodology. This chapter will outline the methods used in this research study consistent with that methodological choice.

### **4.1 Data collection for analysis**

As stressed by Strauss and Corbin (1994, p. 274), the style of extensive interrelated data collection and theoretical analysis in the grounded theory method strives towards the verification of its resulting hypotheses, or statements of relationships between concepts. This is done throughout the course of the research, rather than assuming that verification is possible only through follow-up quantitative research. In this way it is distinguished from quantitative methods and formulates theory as part of the research process itself.

Stern, Allen and Moxley (1984) emphasise that grounded theory research does not follow a series of linear steps but rather ...

... works within a matrix where several processes go on at once ... the investigator examines data as they arrive, and begins to code, categorize,

conceptualise, and to write the first few thoughts concerning the research report almost from the beginning of the study (p. 375).

This is reinforced by Charmaz (2006, p. 10) who, while representing the logic of grounded theory in a linear form from data gathering through to writing through to analysis and reflection, states that the practice is not so structured. Grounded theorists, she says, stop and write whenever ideas occur to them, the best of which sometimes occur late in the process luring the researcher back to the field to gain a deeper view.

## **4.2 Data sources, sampling and analysis**

Consistent with grounded theory, data sources start with field interviews, observations, literature and/or anything that informs the inquiry and begins to build data for continuous comparative analysis.

As outlined in section 1.4 of this thesis, relying on the literature alone in the first instance as a data source is problematic in grounded theory if it results in concept formation without such concepts emerging from those living the reality of the phenomena under study. If an extensive literature review precedes data collection from the research participants in the field, there is a danger that concept generation will commence without the voices of the actors living the experience being heard. While Cutcliffe (2000) posits there is a need for a review of the literature in order to clarify concepts and define terms, he warns that it is important that the reading is not too extensive. He reinforces that approaching 'the field of study with this background knowledge may produce the situation where the researcher has already begun to form tentative conceptual and theoretical links' which is 'inappropriate for grounded theory' (pp. 1478-1480).

In grounded theory, categories are constructed through comparative methods of analysing data. Initial sampling sets up the relevant materials for the study. This is a beginning process which establishes sampling criteria for people, cases, situations and/or settings before the researcher enters the field. Cutcliffe (2000) argues that 'it appears to be logical for the researcher to consider criteria for sample selection prior to starting to collect data' and 'that this purposeful sampling should be considered for

the first interview and possibly the second interview' after which theoretical sampling would follow (p. 1478).

Theoretical sampling is distinctive to grounded theory method where the process of analysis involves concurrently collecting, coding and analysing data and deciding 'what data to collect next, and where to find them, in order to develop ... theory as it emerges (Glaser & Strauss 1967, p. 45).

Therefore, theoretical sampling directs you where to go once the researcher enters the field. Charmaz (2006) explains ...

... its purpose is to obtain data to help explicate your categories which reflect qualities of your respondents' experiences and provide a useful analytical handle for understanding them. That is, theoretical sampling only pertains to conceptual and theoretical development – it is not about representing a population or increasing the statistical generalizability of your results, which does not fit the logic of grounded theory ... we cannot assume to know our categories in advance let alone have them contained in our beginning research questions (pp. 96-101).

Theoretical sampling is conducted to develop the properties of categories until no new properties emerge, which is when data saturation occurs. Categories are then sorted and integrated to form the emerging theory. Indeed it is claimed that theoretical sampling ensures the theory is comprehensive because of its facilitation of achieving data saturation of each category (Urquhart, Lehmann & Myers 2010, p. 372).

### **4.3 Theoretical sensitivity**

Theoretical sensitivity was identified by Glaser and Strauss (1967) in their seminal work on grounded theory as a process that evolves and enhances over time and involves two characteristics. Firstly, it involves the researcher's 'personal and temperamental bent', and secondly, the ability to have theoretical insight into the researcher's area of research and to make something of these (p. 46).

Theorizing means stopping, pondering and rethinking anew ... and involves ... seeing possibilities, establishing connections, and asking questions. To

gain theoretical sensitivity, we look at studied life from multiple vantage points, make comparisons, follow leads, and build on ideas” (Charmaz 2006, p. 135).

Birks and Mills (2011, pp. 62-63) elaborate further on ensuring theoretical sensitivity drawing on the work of Strauss and Corbin’s notion of being alert to when ‘biases, assumptions and beliefs are intruding into the analysis’. They promote constant self-reflexive processes by the researcher and explication of assumptions, theoretical positions, philosophical preferences and methodological alignments. In this way, safeguards are provided to guard against forcing data towards a theoretical concept.

#### **4.4 Memos and concept development**

In their 1967 publication on the discovery of grounded theory, Glaser and Strauss outline the function and importance of memo writing to the research process. They stress that, for generating theory, in addition to developing codes from field notes, memos about the field notes are a way of capturing ‘an immediate illustration for an idea’. This becomes a once only illustration of the particular incident being contemplated, whereas the same incident in the field notes may be used as an example across several codes. This, they argue, avoids using the same illustration of ideas ‘over and over for different properties’ of the data. They further emphasise that the ‘generation of theory requires that the analyst take apart the story within his data’. Sorting of memos and field notes occurs in concert. This functions to break ‘down and out of the story’ in order to obtain clear integration of the theory (1967, p. 108).

Subsequent grounded theorists reinforce and emphasise memo writing as crucial in its encouragement to analyse and code data early in and throughout the research process, and to promote and grow intellectual capital about the data being collected. As such, they assert that memos play a pivotal role in cementing the development of theory from the data (Charmaz 2006, pp. 72-84), (Birks & Mills 2011, pp. 115-116), (Stern & Porr 2011, p. 66).

Birks, Chapman and Francis (2008) expand the notion of memos for qualitative research by proposing four functions of memos, using the mnemonic ‘MEMO’, as ‘Mapping research activities; Extracting meaning from the data; Maintaining momentum; Opening communication’ (p. 70). They propose that memos, as they are

utilised throughout the duration of the research activity, maintain the momentum of the process of conceptualising data as the research progresses and enables review of developing concepts as they occur. They also provide an audit trail of the interpretations of the data and the decisions made to advance conceptual thinking. At the same time, they open communication by conveying ideas to others and by inviting input and comment. As a tool for qualitative research generally, they claim memos will add 'depth, quality and elements of self and shared meaning that characterize qualitative research' (p. 74). As an aid to theory generation specifically, they assert that memoing enhances the process of 'constant comparison' of data in that ...

... the researcher is able to articulate, explore, contemplate and challenge their interpretations when examining data ... The result is the generation of theoretical assertions that are grounded in raw data, yet possess the quality of conceptual abstraction (p. 71).

These notions provide a meaningful framework for this research study that aims to generate theory from exploring mental health nursing practice in a contemporary context where the interpretation of raw data has resonance with the participants as well as integrity as a research process. This study has developed and used an innovative tool that addresses the four functions proposed by Birks, Chapman and Francis and are in the form of Progress Bulletins.

## **4.5 Progress Bulletins: An innovative tool to facilitate a quality research process**

This study developed and utilised Progress Bulletins as an innovative tool, unique to this study. Throughout the study, they were deployed to serve a number of purposes to support the research process and its findings.

Firstly, they were used to keep both actual and potential participants engaged over the period of recruitment, data collection and analysis and served as a token of thanks for their participation and/or interest.

Secondly, they invited participants to comment or add ideas. The content of the Bulletins express ideas and issues emerging from the data over the duration of the research process. For actual participants, the Bulletins served as a cross check with



them that what was emerging reflected their position or were issues with which they could identify in terms of their practice and its underlying values. Any ideas or comments from participants were treated as additional data.

Thirdly, the Bulletins were an aid to me as the researcher to consolidate emerging ideas from memos and interpretations of the data in a form that were coherent and understandable to the participants and others who received them.

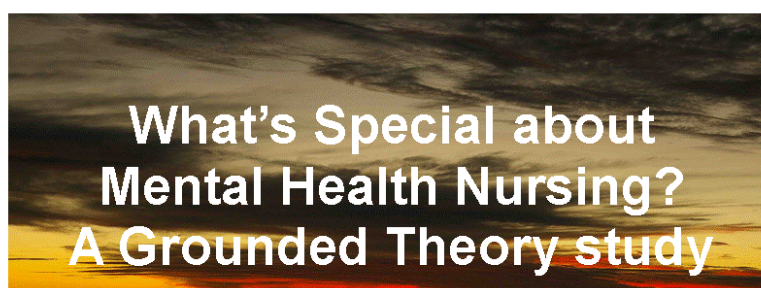
And fourthly, the Bulletins provided an audit trail of concepts as they developed. Thus they provided an artefact of evidence of rigour and credibility in the research process, and in particular to the quality of data management and the data analysis process.

The Bulletins were sent out to all mental health nurses who participated in the study. In addition, they were sent to mental health nurses who expressed an interest as potential participants and wished to receive them, 97 in all. An invitation was also made to an international cohort of mental health nurses who attended presentations of the research at two international conferences in Europe, from which 65 accepted the invitation and received them. The Bulletins were also forwarded to anyone expressing an interest in the research, on a casual basis, if they wished to receive them.

Each Progress Bulletin was kept to one page in length so that recipients were not burdened with a lot of reading. The only exception was the final Bulletin (Progress Bulletin No 17) which was two pages. This constriction forced me, as the writer, to express the emerging ideas as concisely as possible in order to convey the meaning behind the developing concepts in an accessible form that also triggered recipients' thinking and encouraged them to provide feedback and/or comments. Employing this method also demanded a willingness to share the emerging data expressed as beginning and naïve concepts, rather than keeping these ideas to myself in memos alone. The transparency inherent in this process provided assurance that the quality of the research process was being attended on an ongoing basis.

Figure 3 is the first of the Progress Bulletins and illustrates the style and form that all Bulletins took. It was sent after 17 mental health nurse participants had been interviewed. While this Bulletin was an introductory one, it provided an update on what data was beginning to emerge and set the scene for participants' ongoing

engagement in the research process.



## What's it all about?

### The purpose and benefits of the study

This research examines the nature, scope and consequences of mental health nursing from the perspectives of both mental health nurses and consumers. Through in-depth qualitative inquiry the research will develop a theoretical model of mental health nursing practice. Through this process it will be possible to explicate the distinctive contribution made by mental health nurses to service delivery across a range of practice settings. The motivation for pursuing this stems from my long held desire to explore what mental health nurses say, do, think and believe about their practice and how this informs their professional identity. This also creates an opportunity to engage in fresh thinking about how mental health nursing is defined and understood. Is mental health nursing merely an amalgam of other disciplines? Does it hold distinct characteristics? And as a broad subset of these questions, to

what extent does mental health nursing have a positive influence on those who receive it? In short, is it special and if so why?

Knowing the deeper meaning and practice related dimensions of mental health nursing will inform key areas such as autonomous and collective practice, the mental health nursing role and its relationship to professional identity. While this is important in its own right, it may lead to a re-think surrounding education and training for the profession, as well ways to achieve better outcomes for consumers of mental health services.

### Progress to date

The researcher is a PhD student under the supervision of Professors Nicholas Procter and Denise Fassett and ethics approval for the study was obtained from UTAS in mid-February.

In response to an invitation to participate in this study, there have been over 80 expressions of interest. This, I believe, reflects the interest in and identity with the question about what is special

about mental health nursing.

So far, 17 individuals have participated in interviews. These are mental health nurses with specialist qualifications (either credentialed with the Australian College of Mental Health Nurses or eligible for a Credential) and who work autonomously, that is, they determine who they treat and how, and when that treatment is complete.

From these interviews, mental health nurses have revealed practices that are strongly rooted in nursing experience, knowledge and training which result in tangible positive outcomes for the clients they serve. Outcomes reported include decreased hospital admissions, more effective medication management, decreased self-harming behaviours, mood stabilisation, improved social integration and return to meaningful occupational activities.

### A vote of thanks

Thank you to those who have contributed so far and to those who have indicated their willingness to participate — it is appreciated.

### GROUNDING THEORY

A qualitative research methodology for developing theory that is grounded in data systematically gathered and analysed.

**Regular bulletins will keep you updated with the progress of this research study.**

**For further information, contact the researcher:**

**Peter Santangelo on 0438 479392 or by email at:  
psantangelo@bigpond.com**

**Chief investigators:** Professors Nicholas Procter and Denise Fassett

Figure 3: Progress Bulletin No 1: What's it all about?

The subsequent five Bulletins (see Appendix 3), following interviews with an increasing number of participants, provided information about the emerging concepts from the data and posed questions about these to encourage comment. Bulletins 7-17 represented the consolidation of the data into major categories and their properties, and the hypotheses formulated from them towards theory generation. A more detailed discussion of these is addressed in Chapters 5 and 6.

## **4.6 Theoretical integration and generation**

The integration of ideas from the data demands analysis at a sophisticated level in order to achieve the generation of a theory about the phenomena of interest.

The core concept and other concepts come from the data but theory does not just build itself; in the end, it is a construction built by the analyst from the data provided by the participants (Corbin & Strauss 2008, pp. 265-266).

According to Birks and Mills (2011, pp. 113-115) , studies which aim to go beyond descriptive analysis to theory generation require the application of advanced analytical strategies in order to raise the analysis to the highest conceptual level possible. For the integration of a grounded theory, a study needs ‘an identified core category’, ‘theoretical saturation of major categories’ and ‘an accumulated bank of analytical memos’.

## **4.7 A schema for grounded theory methods in this study**

Application of grounded theory research methods used in this study were derived from the writings of Strauss and Corbin (1990), Strauss and Corbin (1994) and Stern et al (1984). In addition, incorporated were components of grounded theory method derived from Glaser and Strauss (1967) and Charmaz (2006) who, in her first Chapter, claims that many of the distinguishing components of practice of grounded research that she espouses are true to those expounded by Glaser and Strauss. In addition, Birks and Mills (2011, pp. 9-13 & 91), provide a ‘conceptual ordering of essential grounded theory methods’ they consider have emerged in the contemporary dialogue.

Merging and extending the above aspects of grounded theory methods provided the schema for grounded theory methods used in this study which is outlined in Figure 4.

### **1. Data collection and analysis**

*Data may be collated from a variety of sources including interviews, observation, documents or a combination of these. The collection of data occurs in a naturalistic setting and must include the perspectives and voices of the people studied.*

*Data collection and analysis occur concurrently using the constant comparative method, making comparisons between data throughout each stage of analysis.*

*From this process, analytic codes and categories are constructed which are generated from the data rather than from pre-conceived, logically deduced hypotheses.*

### **2. Concept formation and development**

*Concepts begin to form as data are received and compared and theory development is advanced during each step of data collection and analysis. Decisions are made about the relative importance of the issues as they emerge from the data, often using the words of the participants themselves.*

*More substantive codes are constructed through inductive and deductive modes and compared with more incoming coded data after which categories, which fit with patterns in the data, take shape.*

*Throughout this process, there is an emphasis on conceptualisation of data rather than mere description. This is facilitated by writing memos that generate ideas, hunches and abstractions about interrelationships of data and emerging patterns and themes, or hypotheses. They function to elaborate categories, specify their properties, define relationships between them and identify gaps.*

*Concepts are further developed as this process gains momentum and the researcher becomes more familiar with the factors, elements and processes generated from the data and categories. Refinement of the data is achieved through reducing categories according to clusters or connectedness and selective sampling of the data and literature. This sampling is aimed toward theory construction and not for population representativeness.*

*When selective sampling is no longer generating anything new, saturation of the categories occurs. The result is the identification of a comprehensible core category and subsidiary categories representing the psycho-social process pertinent to the phenomenon of interest in the research.*

### **3. Theory generation and reporting**

*The process of integrating theoretical concepts is facilitated by the use of theoretical codes which specify possible relationships between categories developed from previous coding. They can be drawn from existing theories which can add explanatory power to the theory generated by its association with a theoretical body of knowledge. The ultimate outcome is an integrated and comprehensive grounded theory that explains a process in relation to a particular phenomenon.*

*Sorted memos become the basis of the research report which presents a clear and precise picture of the theory, substantiates it by supporting data from field notes and the literature, and gives the reader an idea of where the data came from, how they were rendered, and how the concepts were integrated.*

**Figure 4:** Schema for grounded theory methods used in this study

## **4.8 The research participants**

This research study focused on the interaction between mental health nurses, the people they served and the environment in which this occurred. The aim was to explore if this psycho-social process was one that characterised the distinct practice and identity that is mental health nursing. It aimed to explore the essence of mental health nursing practice in terms of its nature, scope and consequences.

### **4.8.1 Mental health nurse participants: A purposive sample**

According to Lo-Biondo-Wood and Haber (2006, p. 268), purposive sampling is usually used by a researcher to select participants who are considered to be typical of the population being studied. In a grounded theory context, Stern and Porr (2011, p. 51) assert that a purposive sample can 'provide rich in-depth accounts and provide data that are conceptualizable'.

To this end, a purposive sample was chosen in order to maximise the opportunity to collect data that would enlighten the phenomena of interest. This is consistent with this study's underlying assumptions, outlined in Chapter 1, that the mental health nurse participants targeted were those who could best inform the study in both breadth and depth. The parameters for the inclusion of participants are articulated in the following selection criteria.

#### **4.8.1.1 Selection criteria**

The first criterion for inclusion in this study was that the participants were mental health nurses with specialist mental health nursing qualifications and experience. The criteria used by the Australian College of Mental Health Nurses (ACMHN) for their Credential for Practice Program was used as the basis for determining this criterion (2013a).

The second criterion related to nurses whose practice was autonomous. That is, mental health nurses who are in a position where they decided who they accepted into their practice based on self-assessed competence and expertise, what treatments were delivered by them, and when the client was discharged from their care. The criterion of autonomous practice was determined by self-evaluation by the participant using the above definition. The expectation embedded in this criterion

was that the mental health nurse took sole responsibility and accepted accountability for their practice throughout the process of engagement with their client. It is posited that this level of autonomous practice placed participants in a strong position to comment on the nature, scope and consequences of the discipline in all its breadth and depth.

The detail of these specific eligibility criteria is outlined in Appendix 4.

The range of possibilities in terms of access to these participants were mental health nurses working in private or independent practice, perhaps in remote areas where they were the only decision-maker in terms of their practice or perhaps in nurse-led facilities where the decision for entry was nursing driven. Or indeed, it could also be mental health nurses working as employees of organisations who nonetheless perceived their practice in the autonomous way previously described.

#### **4.8.2 Other participants**

Other participants potentially solicited to take part in this research included clients of mental health nurse participants, their carers and/or family, and other health care colleagues professionally associated with mental health nurse participants. These participants were those who were able to comment meaningfully and authoritatively on their perspective of the work undertaken by the mental health nurse. Criteria for this cohort's eligibility to participate in this study are included as Appendix 5.

### **4.9 Data generation**

The primary means of data collection designed for this study involved interviews with participants. In addition, demographic data forms were devised for mental health nurse participants and survey questionnaires were formulated to capture data where interviews with participants were not possible.

#### **4.9.1 Semi-structured interviews and /or focus groups**

It was considered that face-to-face interviews with the research participants would yield the richest data in relation to this study. The issues being explored were concerned with the status of mental health nursing as a professional entity and its impact on the people it served. In keeping with the underlying philosophy of

grounded theory as used in this study, that of symbolic interactionism, face-to-face interviews and/or focus groups with participants should supply sufficient data about the nature, scope and impact of these interactions in order to develop a base for adequate data analysis and interpretation.

While direct observations of the interaction between mental health nurses and their clients would have afforded access to particular nuances in this interaction, it is argued that this would have been too intrusive into the personal nature of these substantively therapeutic and often emotionally intimate interactions. The purpose of the study was not the detail about content of the therapeutic interaction, but more about the process of the interaction. If data were collected retrospectively as recount data about these interactions, as they were in this study, it is argued that this would provide the opportunity and mind space for research participants to be reflective about the interaction in hindsight, affording a level of abstraction from their perspective that would add value to the richness of the data collected.

Both semi-structured interviews and focus groups were facilitated with broad, open questions. Particular techniques and suggestions that fit with grounded theory method are available for the execution of such interviews and focus groups, including suggested initial open-ended, intermediate and ending questions (Charmaz 2006, pp. 25-35). Sample questions used for both semi-structured interviews and focus groups were informed by these and are included as Appendices 6 and 7 for the mental health nurse and other participants respectively.

#### **4.9.2 Obtaining data on client outcomes**

The areas of interest in this research study were not confined to exploring the nature and scope of mental health nursing alone, but also its impact and its particular or distinct contribution to positive outcomes for the persons it served. Data related to outcomes were potentially accessible through subjective oral accounts from participants and/or from other objective data. This latter data could take the form of written case notes and/or other metrics that may be collected.

However, the purpose of a focus on outcomes was not an evaluation of success, but more an exploration of the interventions where success was apparent. Therefore, if available data on outcomes were anecdotal only, taken at face value they were

deemed to satisfy evidence for apparent success and a catalyst for exploring specific interactions that were distinctively nursing in focus that contributed to a positive outcome.

### **4.9.3 Demographic data of the mental health nursing participants**

As the focus of this research study was about the practice of professional mental health nursing, it is argued that demographic data were required on the mental health nurse participants only. The purpose of such data was to provide a description of this cohort that may help explain any influences on the manner in which they practiced, or reveal attributes that were distinctively nursing in nature. For example, information on age and years of practice may denote exposure to particular aspects of training and/or education and practice settings and experience that influence practice. Similarly, under-graduate and post-graduate qualifications may influence particular orientations of care and interventions and the knowledge on which they are based. The data set for demographic data is attached as Appendix 8.

Specific demographic descriptors of the other participants, it is argued, were not significant to the professional practice issues of concern with this study and therefore this personal information on this cohort was not warranted.

### **4.9.4 Survey questionnaires for other participants**

In relation to participants other than mental health nurses, where face-to-face interviews or focus groups were not possible, albeit preferred, survey questionnaires were designed to capture data related to their perspective of the professional input they received. A sample survey questionnaire is attached as Appendix 9.

## **4.10 Ethical considerations**

Consistent with grounded theory method, data can be derived from any source. For this research study, interviews with mental health nurses in the public and private health care systems were utilised. Data were also derived from other participants, namely clients of mental health nurses and other healthcare colleagues, either by interview or by survey questionnaire or both, depending on avenues of access to participants. Therefore, as this research study used human participants, it required



ethics approval. The risks associated with this research study are claimed to be low and outweighed by its relative benefits.

The overarching document that guides institutions and researchers in responsible research practices is the Australian Code for the Responsible Conduct of Research (The Code) (Australian Government 2007a). This publication is jointly issued by the National Health and Medical Research Council (NHMRC), the Australian Research Council (ARC) and Universities Australia. Its aim is to encourage a research culture that demonstrates honesty and integrity, respect for human research participants, animals and the environment, good stewardship of public resources, acknowledgement of the role of others in research, and responsible communication of research results (Australian Government 2007a' p. 1.3).

The Code, in Part A of the document, outlines the expected standard for each of the above domains of responsible research. Part B of the document deals with breaches of the Code and misconduct in research.

Two other documents are also relied on in relation to the social and ethical considerations of this research study.

Firstly, there is the National Statement on Ethical Conduct in Human Research. This document was developed jointly by NMHRC, ARC and the Australian Vice-Chancellors' Committee (AVCC). It is identified as a 'user guide' for any research with human participants and intended to be used by researchers, ethical review bodies, those involved in research governance, and by research participants. Its content sets out national standards for the ethical design, review and conduct of human research and as such is relied on heavily in formulating the appropriate issues for an ethics application (Australian Government 2007b).

Secondly, there is the Statement on Consumer and Community Participation in Health and Medical Research. This document is the result of collaboration between the NHMRC and the Consumers' Health Forum of Australia Inc. (CHF) which acknowledges the contribution that consumers can make to health and medical research and their right to do so (Commonwealth of Australia 2002, p. v). A companion document, developed by NHMRC provides a resource pack for such research. This was used as a background document for the research study as

consumers and other health care workers were invited to be participants (Commonwealth of Australia 2004).

#### **4.10.1 Ethics approval**

An ethics application for this research study was submitted in February 2012. This application was approved in late February 2012. A copy of the approval letter, with acknowledgement of each of its 13 appendices, is attached as Appendix 10.

#### **4.10.2 Ethical and social considerations relevant to this research study**

Ethical conduct of research is underpinned by core values and principles, and described by the National Statement on Ethical Conduct in Research as:

- a) Respect for human beings. This value is central to ethical conduct and includes recognising the value of human autonomy and where there is diminished or no autonomy, empowerment and/or protection of the person/s where applicable;
- b) Research merit and integrity, which refers to the value of the research itself and the integrity of the researcher carrying it out;
- c) Justice, which ensures that benefits of research are achieved through just means, are distributed fairly and involve no unjust burdens; and
- d) Beneficence, exercised by assessing potential risks and benefits, sensitivity to the welfare and interests of people involved in the proposed research, and reflection on the social and cultural implications of the research by the researcher (Australian Government 2007b, p.11).

Each of the above underlying values and principles were addressed in terms of the specific requirements for this research study. In addition, issues of consent and confidentiality were considered.

Also, the National Statement on Ethical Conduct devotes a chapter to qualitative methods of research. Because the nature of this methodology involves examination of people's lives, experiences and behaviours, it provides specific guidelines for conduct under the headings of each of the underpinning values and principles

(Australian Government 2007b, pp. 25-28). Specific issues for the research study related to this aspect are also incorporated in the following section.

#### **4.10.2.1 Respect for human beings**

Participation in research is the result of a choice made by participants. This requirement for consent demands that it is a voluntary choice, based on sufficient information and adequate understanding of both the proposed research and the implications of participation in it, adequate understanding of the purpose, methods, demands, risks and potential benefits of the research. It must be presented in a way so that there is mutual understanding between researchers and participants with an opportunity for participants to ask questions and to discuss the information and their decision with others if they wish. Consent may be expressed orally, in writing or by some other means (Australian Government 2007b, p. 19).

Clear and concise consent forms were developed for mental health nurse and other participants guided by the National Statement on Ethical Conduct in Research and are attached as Appendices 11 and 12 respectively.

The National Statement on Ethical Conduct also states that researchers and their institutions should respect the privacy, confidentiality and cultural sensitivities of the participants and, where relevant, of their communities (Australian Government 2007b, p. 13), how privacy and confidentiality will be protected (2007b, p. 20), that there is an adequate plan to protect the confidentiality of data (2007b, p. 24), and should include measures to protect the degree of confidentiality that participants wish to maintain (2007b, p. 42). Confidentiality is the obligation of people not to use private information for any purpose other than that for which it was given to them (Australian Government 2007b, p. 99).

All participants were coded with an alpha-numeric code, their identity kept separately and only accessible to the research team. All data were secured either by password protection for electronic data or within a locked cabinet for hard data. The consent forms outline the measures put in place to ensure anonymity of each participant as well as controls put in place to secure any data gathered.

In addition, researchers should consider whether respect for the participants requires that the accuracy or completeness of each interview transcript should be verified by

the relevant participant before analysis is complete (Australian Government 2007b, p. 28). Interviews were recorded and participants were given a choice of receiving a copy of the transcripts of any recording should they wish. Transcripts were identified by code only so that participants were not identified.

The nature of this research and its method did not impinge upon any cultural sensitivity.

#### **4.10.2.2 Research merit and integrity**

In terms of justifiability of this research project, Chapters 1 and 2 outline the original contribution this research will potentially make to contemporary mental health nursing knowledge and practice and by association, its benefit to those they serve. An overview of the literature supporting justification for the study was submitted with the ethics application and approved. Chapters 3 and 4 outline the research design of grounded theory as the best suited to the purpose of the research.

To ensure integrity of the research process, as with all PhD studies, two supervisors were engaged to provide supervision which has been both regular and consistent. One supervisor was an eminent mental health researcher and the other a senior academic with extensive experience and who has worked broadly across the profession.

#### **4.10.2.3. Justice**

It is not anticipated that the results of the research will be restricted in any way. Dissemination of research findings has been through conference presentations nationally and internationally throughout the progress of the research, and a commitment to submission of journal publications. From the commencement of the study, presentations have been made at six international (three in Europe and three in Australia), one national and five local conferences, the details of which are attached as Appendix 13. In addition, 17 Progress Bulletins depicting the whole process of the research have been disseminated nationally and internationally and are readily available to anyone on the University of Tasmania website. Copies of the findings of the research, particularly in the form of published articles, will be accessible and personal copies of the thesis made available if requested.

#### **4.10.2.4 Beneficence**

All risks and benefits are outlined in the information sheets about the research study for mental health nurse and other participants respectively in Appendices 14 and 15.

In interviews, participants were asked about their professional practice and no sensitive or confidential material about that practice was explored. In relation to accessing the perspective of clients, this involved information about the practice of their treating clinician and not about any sensitive material dealt with in the course of their contact with them. This issue was addressed specifically in the ethics application and outlined how this study complies with section 4.5 of the National Statement on Ethical Conduct in Human Research and was approved.

The consent form for clients reflects the purpose of the research and specifically outlines the nature of the material sought with an emphasis on sensitive material not being sought.

Any potential risks, it is claimed, do not involve aspects that would result in physical, psychological, social, economic or legal harm nor devalue the participants' personal worth in any way.

In addition, as the researcher responsible for the collection of data from participants, I am an experienced mental health nurse and well skilled and sensitive in interpersonal relationship management thereby further reducing any potential risk of harm and/or discomfort.

### **4.11 Data collection process**

Recruitment and interviews of participants commenced in March 2012 after ethics approval and involved the following processes.

#### **4.11.1 Recruitment and selection of participants**

An expression of interest to participate in this study was sent out via professional networks. The Australian College of Mental Health Nurses (ACMHN) was requested to send out an expression of interest to its members, of whom there were approximately 3,000. About 1,100 members were Credentialed Mental Health Nurses and therefore represented a cohort eligible to participate within the study's criteria for selection of participants. The ACMHN acquiesced to this request after

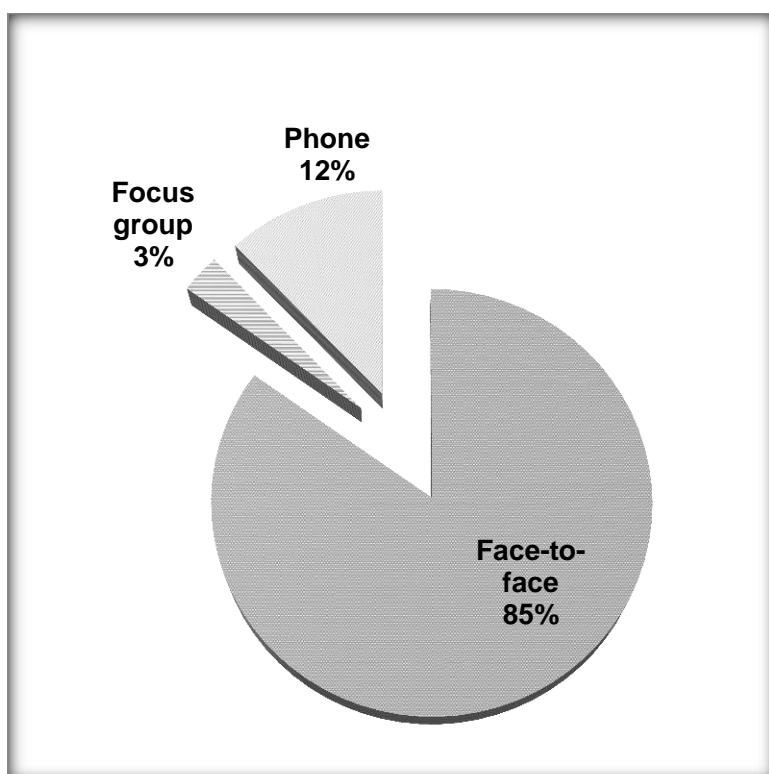
having sighted the Ethics approval letter and an email was disseminated to its members. In addition, an expression of interest was distributed at the ACMHN 5<sup>th</sup> Primary Mental Health Care Conference in March 2012 (Appendix 16).

These invitations to participate yielded over 120 potential participants. All potential participants were responded to by email giving further information about the research study. Over the period from April 2012 to November 2012, progressive recruitment resulted in interviews with 36 mental health nurses, five clients of mental health nurse participants and one health care colleague of a mental health nurse participant, 42 participants in total.

The number of participants was not estimated in the original proposal for this study as, consistent with grounded theory methodology, the extent of participation is dependent on reaching 'data saturation', and therefore not quantifiable until interviews and analysis is undertaken.

#### **4.11.2 Interviews with participants**

The type of interview conducted with mental health nurse participants is represented in Figure 5. All interviews with participants were individual face-to-face interviews with the following exceptions. Face-to-face interviews were not possible for three mental health nursing participants and therefore these were conducted by telephone. One group of four mental health nurses agreed to participate in the study and requested to be seen together as a focus group and this request was acquiesced to. One health care worker participant preferred to participate by survey questionnaire only.



**Figure 5:** Interview type by percentage - mental health nurses

All interviews were audio recorded. Of the face-to-face interviews with mental health nurses, the majority (n=29) were interviewed at their place of work, the other seven choosing a venue more convenient to them. Average duration of each interview was 56 minutes. Of the five clients interviewed, all were interviewed face-to-face, three at the centre where they saw their mental health nurse and two preferred to be interviewed at their home. Their interviews were shorter and on average lasted just over 30 minutes.

#### **4.11.3 Data management**

All audio-taped interviews were transcribed by an external transcriber and assigned an alpha-numeric code to preserve the anonymity of the participants. Individual identification codes were used as file names for the audio files forwarded to the external transcriber, for the subsequent transcribed documents, and as the identifying code for the demographic data on mental health nurse participants

(Appendix 8). All documents entered into NVivo software<sup>8</sup> for analysis also bore the same codes.

All paper files, namely demographic data on mental health nurse participants, were stored in a lockable filing cabinet. All electronic files were stored in a password protected computer and password protected hard drive backup storage devices.

All group emails sent to participants or potential participants did not identify the identity of the group to whom the emails were sent. This was executed by sending the email to my email address with all other recipients blind copied<sup>9</sup> into the email.

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<sup>8</sup> 'NVivo' is a product of QSR International and is software that supports qualitative and mixed methods research. It lets the user collect, organise and analyse content from interviews, focus group discussions, surveys, audio and social media data, You Tube videos and web pages.

<sup>9</sup> A blind copy, or more correctly a 'blind carbon copy' (Bcc), is a copy of an email message sent to a recipient whose email address does not appear in the message. When you use Bcc to send an email to more than one person, the email addresses of your recipients will not be displayed in the emails.



# Chapter 5

## ***Analysis of data and findings***

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Data analysed for this study included the demographic data collected on the mental health nurse participants, and the data from all participant interviews to formulate categories and generate theory.

Analysis of the demographic data gives an overview and profile of the mental health participants in this study and affirms their capacity as a purposive sample to confidently inform this inquiry. As detailed demographic data was not collected on other participants, a brief description of their profile is reported.

The method of analysis of the data obtained from interviews with participants is described. Following this is a detailed interpretation of the interview data in the context of the nature, scope and consequences of mental health nursing, the three major categories emanating from these, along with their properties supplemented with excerpts from participants to illustrate concepts as they emerged. A consolidated interpretation of the data for each of these categories is provided as a hypothesis for each category. This analysis is augmented with theoretical sampling from the literature where relevant.

The foregoing analysis and formulation of hypotheses, through further conceptual development, culminates in the construction of a core category and psycho-social process of the phenomena explored. Again, the process of theoretical sampling has consulted the literature to follow through leads from the data and fill gaps in and between categories.

### **5.1 Profile of participants**

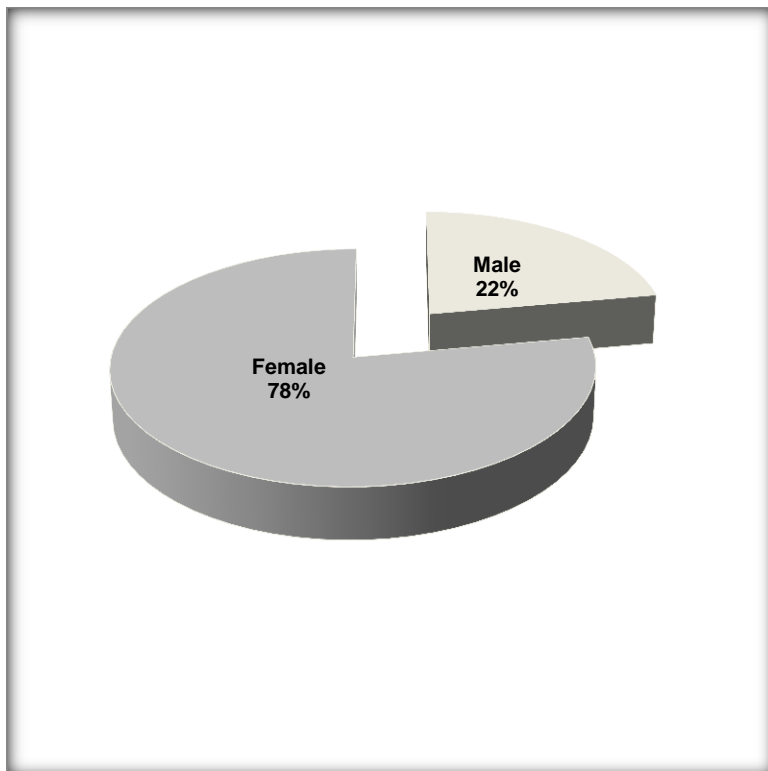
#### **5.1.1 Characteristics of mental health nurse participants**

The primary participants in this study were mental health nurses. The demographic data on these participants provide evidence of their eligibility to participate. The data also describe professional mental health nursing characteristics of this cohort that may help explain any influences on the manner in which they practiced or reveal attributes that are distinctively nursing in nature.

Each of the 36 mental health nurse participants completed the demographic data form, the data from which were entered into a computer spreadsheet for collation and are described in the following sections. Interpretation of the characteristics and profile of this cohort is discussed at the end of this section.

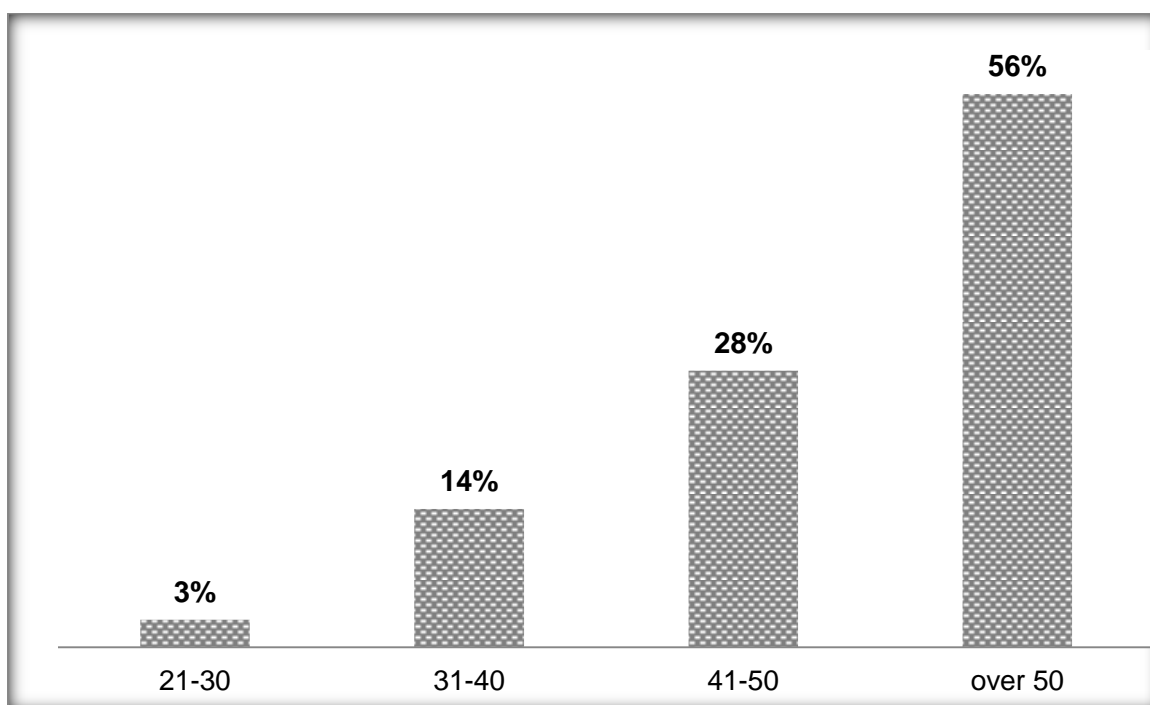
#### **5.1.1.1 Age and gender distribution**

Of the 36 mental health nurses interviewed, 28 were female and eight were male (Figure 6).



**Figure 6:** Gender of participants

Thirty (or 84%) of the participants were over 40 years of age with 20 of these over 50 (Figure 7).



**Figure 7:** Age distribution of participants

### **5.1.1.2 Position identity and qualifications**

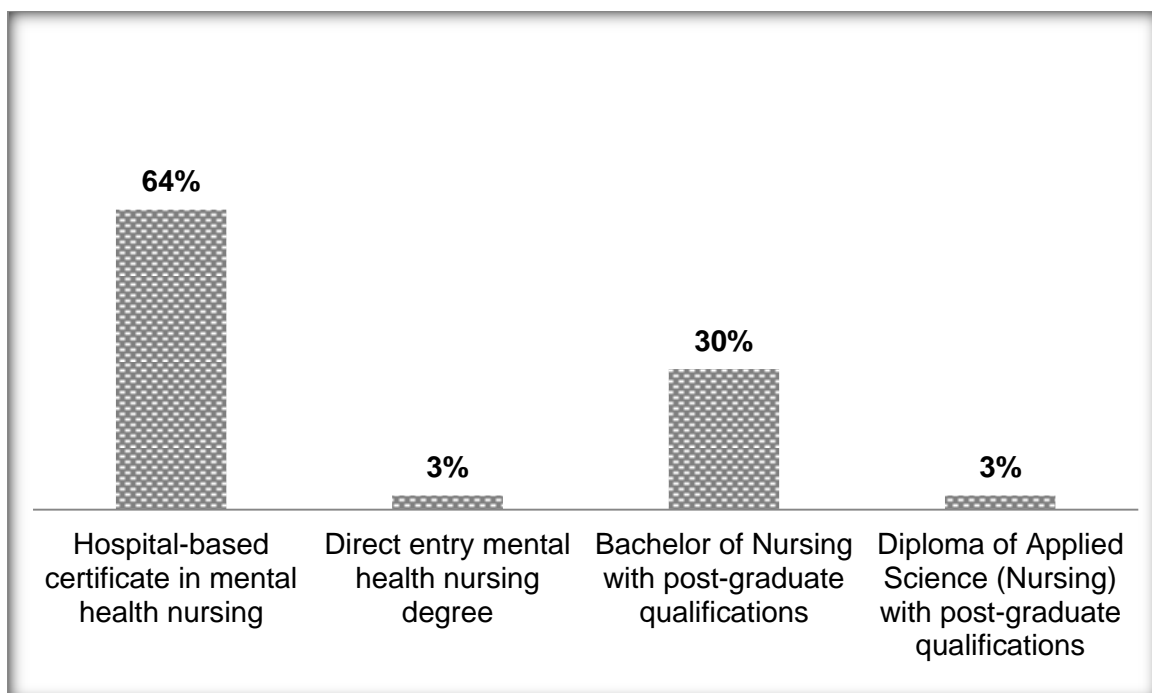
Participants were asked to identify their position status from six choices, these being Registered Nurse, Credentialed Mental Health Nurse, Clinical Nurse Specialist, Nursing Manager, Nurse Practitioner, or Other. While all of these participants were Registered Nurses, the other categories were designed to identify roles and responsibilities over and above this basic position status in order to provide a broader description of their profile as specialist mental health nurses.

Twenty-nine participants, or just over 80%, identified their position status as Credentialed Mental Health Nurses with five of them identifying other roles respectively as psychotherapist, psychoanalyst, Nurse Practitioner, mediator and academic. Of the remaining seven mental health nurses, two identified their position as Registered Nurse and the remaining five claiming roles of Clinical Nurse Specialist, Nurse Practitioner candidate, clinical educator, clinical practice consultant and clinical coordinator.

Eligibility criteria for participation in this study required specialist qualifications that formally recognised participants as mental health nurses. Qualifications eligible were

certificated hospital-based training programs in mental health nursing<sup>10</sup> prior to 1986, or a Bachelor of Nursing degree or equivalent with the attainment of post-graduate qualifications in mental health nursing at Graduate Diploma or Masters level.

Twenty-three participants obtained their primary qualification for mental health nursing in hospital-based programs. One participant had a 'Mental Health Nursing direct entry' degree. Eleven participants had a Bachelor of Nursing degree and one had a Diploma of Applied Science (Nursing) with post-graduate qualifications in mental health nursing (Figure 8).



**Figure 8:** Participants' primary qualification for mental health nursing

Tertiary post-graduate qualifications in mental health nursing were not required for participants who had obtained a qualification specifically in mental health nursing, that is those with hospital-based certificates and direct entry mental health degrees. For those participants who obtained a Bachelor of Nursing degree or equivalent that are not mental health nursing specific, tertiary post-graduate qualifications in mental health nursing was required. While some of the participants held only one formal

<sup>10</sup> Hospital-based training programs in Australia comprised generally a three year program of employment in a psychiatric hospital with a prescribed amount of theoretical input delivered as full-time blocks of education distributed through the three year term. This culminated in an examination leading to a Certificate qualification. Nurses with general nurse qualifications could undergo a similar program of 18 months to achieve the same psychiatric nursing certificate.

qualification for mental health nursing, all satisfied the eligibility criteria for recognition as a specialist mental health nurse as defined in this study (Appendix 4).

Some participants had obtained tertiary post-graduate qualifications in areas other than mental health nursing, for example in counselling and psychotherapy. Other formal and informal courses of study related to participants' practice were not recorded.

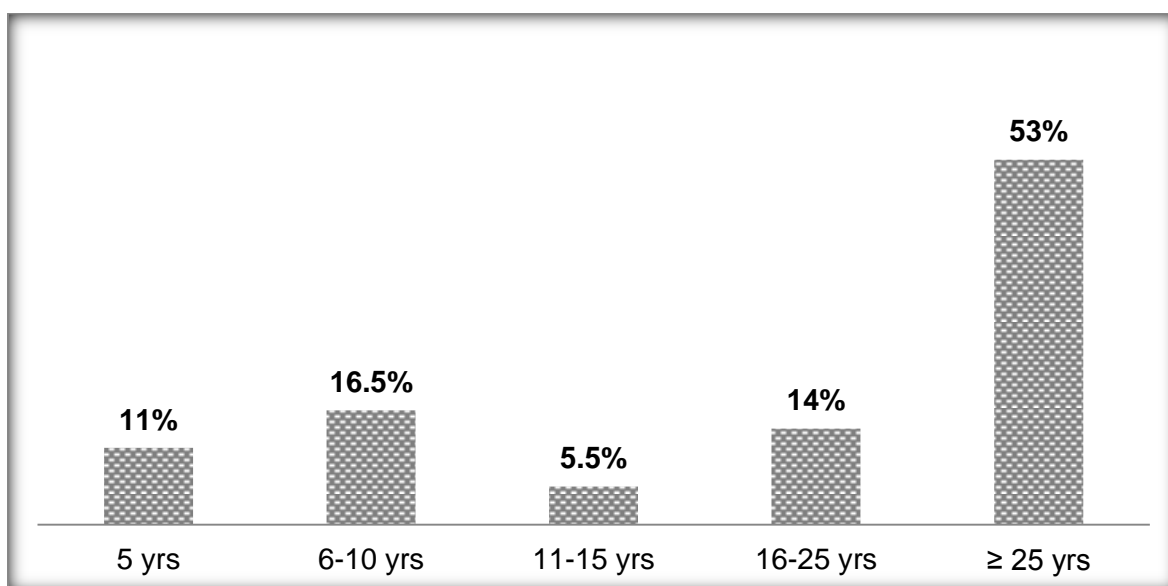
Table 2 outlines the distribution of participants in terms of their qualifications and includes those credentialed with the ACMHN.

**Table 2:** Distribution of the types of participants' qualifications for mental health nursing

<b>Primary qualification</b>	<b>Single formal qualification only</b>	<b>Post-graduate qualifications in mental health nursing</b>	<b>Other post-graduate qualifications</b>	<b>Credentialed Mental Health Nurse</b>
<b>Hospital-based certificate in mental health nursing (n=23)</b>	9	11	8	21
<b>Direct entry mental health nursing degree (n=1)</b>	1	0	0	0
<b>Bachelor of Nursing degree (n=11)</b>	0	11	2	8
<b>Diploma of Applied Science (Nursing) (n=1)</b>	0	1	0	0
<b>TOTAL</b>	<b>10</b>	<b>23</b>	<b>10</b>	<b>29</b>
<b>Percentage of Total (n=36)</b>	<b>28%</b>	<b>64%</b>	<b>28%</b>	<b>81%</b>

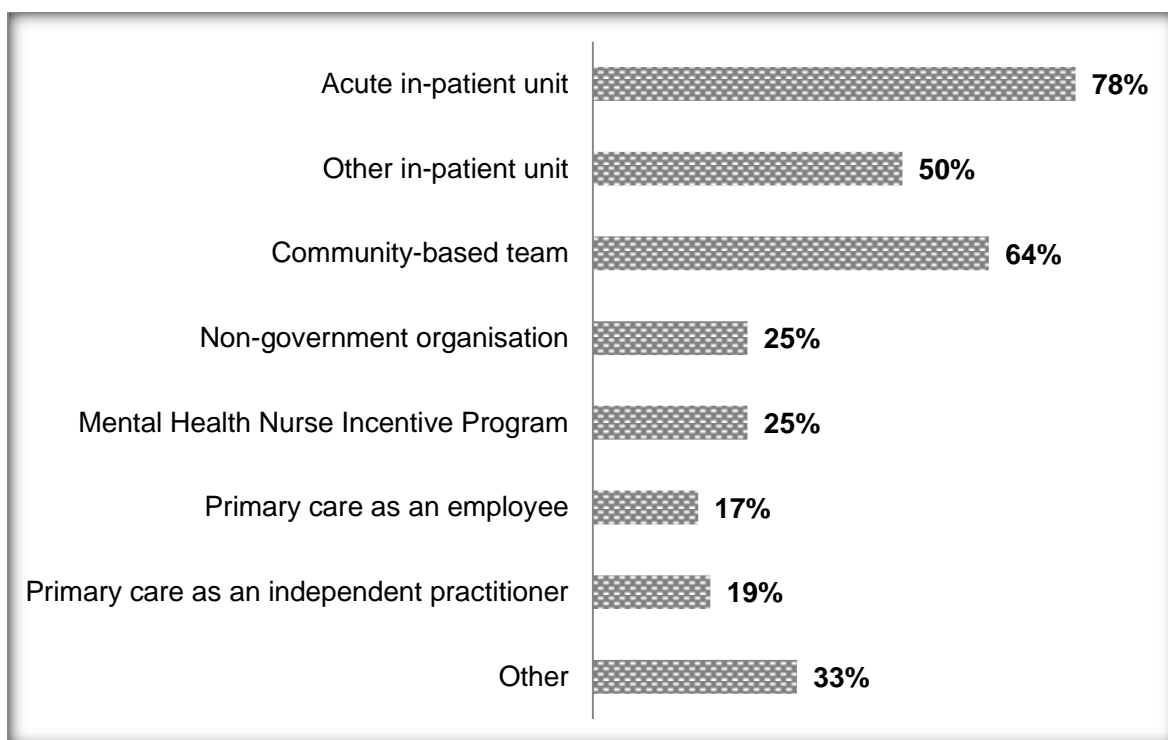
### 5.1.1.3 Past practice experience

Not one participant had less than five years' experience as a mental health nurse and over half (n=19) had over 25 years of experience (Figure 9).



**Figure 9:** Participants' experience as a mental health nurse

Participants also had a broad range of experience across different practice settings, the most prominent of which were in-patient and community-based settings (Figure 10).



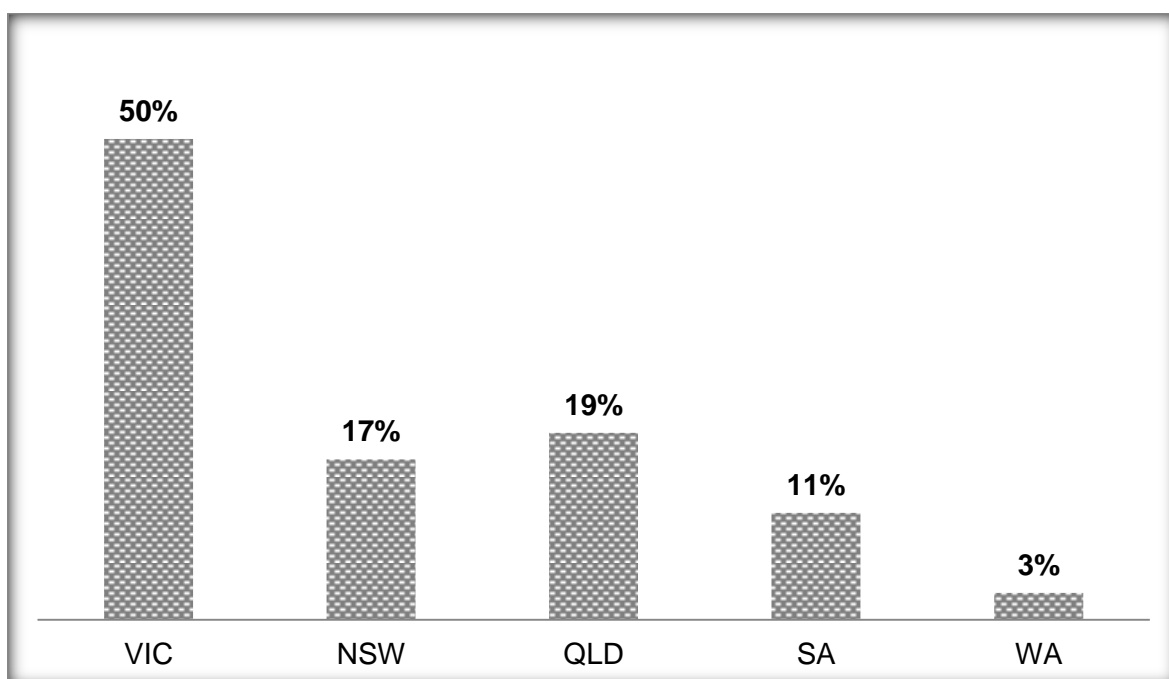
**Figure 10:** Participants' range of experience

Where participants specified, 'Other in-patient units' included psychiatric rehabilitation and extended care, child and adolescent, drug and alcohol, psychiatric

intensive care, therapeutic community,<sup>11</sup> and private psychiatric units. Where specified, 'Community-based team' included adult, child and adolescent assertive and continuing care services including early psychosis intervention. The category of 'Other' settings included roles in education, forensic and child and adolescent mental health, co-morbid drug and alcohol/mental health settings, as well as emergency department and mental health consultation/liaison services.

#### 5.1.1.4 Geographic distribution and current practice setting of participants

The distribution of mental health nursing participants were across five States with 18 located in Victoria, seven in Queensland, six in New South Wales, four in South Australia and one in Western Australia<sup>12</sup> (Figure 11). While expressions of interest from mental health nurses in Tasmania, the Northern Territory and the Australian Capital Territory were encouraged, they did not yield their participation.



**Figure 11:** Participants' location, by percentage

<sup>11</sup> Therapeutic communities are treatment milieux based on democratic administration and collective rule setting which became popular post World War II in the treatment of returned soldiers and in the context of social psychiatry and radical reform in psychiatry. The term was coined to describe a method 'in which all of the elements of life in the hospital community could be seen as therapeutically intentioned (Winship 2009, pp. 393-398).

<sup>12</sup> This information was not included as part of the Demographic Data Form (Appendix 8). Data on geographical location were derived from the confidential database of participants and has been included as additional demographic data.

A formal government evaluation of the MHNIP indicated a greater uptake of the program in Victoria compared to other States and Territories (Australian Government Department of Health and Ageing December 2012, p. 36). This is consistent with the greater participation in this study by Victorian mental health nurses, two-thirds of whom (n=12) were working primarily in the MHNIP.

The practice settings in which mental health nurse participants worked are represented in Table 3.

**Table 3:** Range and type of practice settings of mental health nurse participants at the time of interview

<b>Community-based practice settings</b>	<b>Number of mental health nurses</b>
Mental Health Nurse Incentive Program	21
Independent practice in primary care	11
Employee of a primary care practice	2
Non-government organisation	2
Community mental health team – public health	6
Private mental health nursing practice	1
Health consultant	1
<b>Total</b>	<b>44 or 88%</b>
<b>Other practice settings</b>	
Acute in-patient – public health	1
Other in-patient – public health (Post-natal unit)	1
Academic	1
Mental health consultation-liaison	1
Private hospital coordinator	1
Hospital out-patient clinic for psychiatric trauma	1
<b>Total</b>	<b>6 or 12%</b>
<b>GRAND TOTAL</b>	<b>50 or 100%</b>



The range of practice settings in which mental health nurse participants worked varied in type and 13 different settings were identified. Some of the 36 participants provided services across more than one practice setting. Therefore, the number of instances of involvement in the identified settings by the 36 mental health nurse participants, recorded in Table 3, amounted to 50, taking into account the multiple roles of some nurses. The vast majority of settings (88%) were community-based settings in one capacity or another.

Of the 36 mental health nursing participants, 23 worked in one practice setting alone, again largely community-based, as outlined in Table 4. The remaining 13 worked in two practice settings with the exception of one of these working across three practice settings. Only one participant did not work, for some part of their practice, in a community-based setting. This distribution is outlined in Table 5.

**Table 4:** Practice settings in which mental health nurse participants provided their practice to one setting only

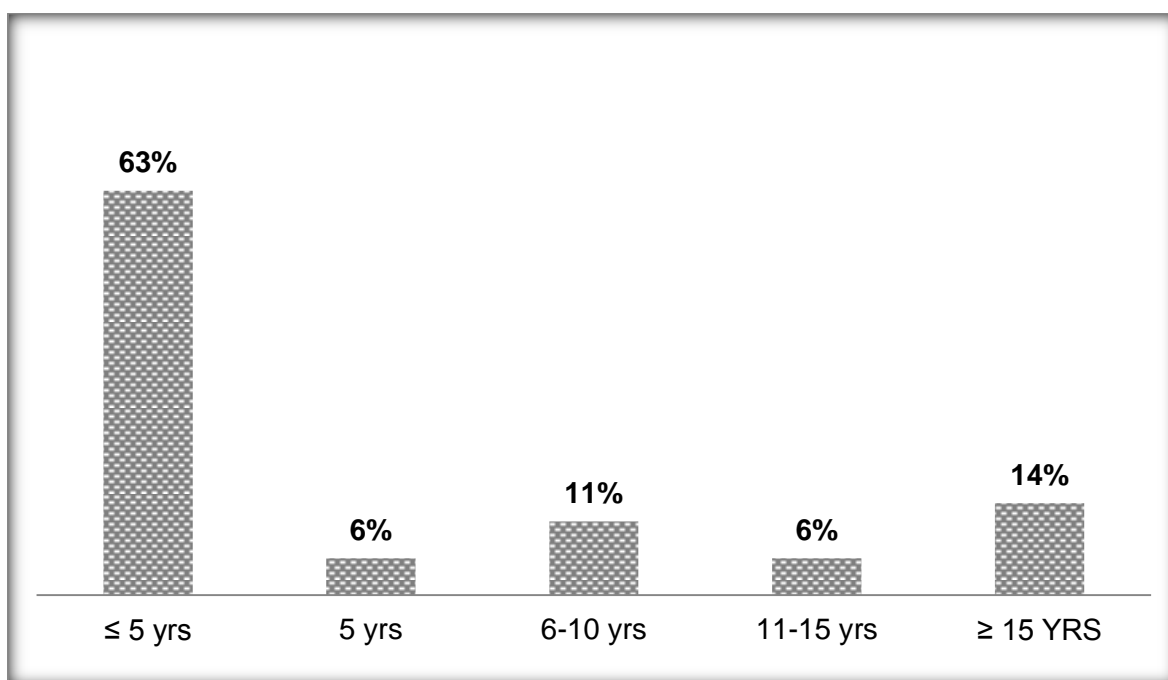
<b>Community-based practice settings</b>	<b>Number of participants</b>
Mental Health Nurse Incentive Program	11
Independent practice in primary care	3
Non-government organisation	1
Community mental health team – public health	5
Private mental health nursing practice	1
<b>Total</b>	<b>21 or 91%</b>
<b>Other practice settings</b>	
Mental health consultation-liaison	1
Hospital out-patient clinic for psychiatric trauma	1
<b>Total</b>	<b>2 or 9%</b>
<b>GRAND TOTAL</b>	<b>23 or 100%</b>

**Table 5:** Number of mental health nurse participants working across more than one practice setting

<b>Practice settings</b>	<b>Number of participants</b>
Mental Health Nurse Incentive Program + Independent practice in primary care	6
Mental Health Nurse Incentive Program + Independent practice in primary care + Community mental health team – public health	1
Mental Health Nurse Incentive Program + Employee of a primary care practice	1
Mental Health Nurse Incentive Program + Non-government organisation	1
Mental Health Nurse Incentive Program + Private hospital coordinator	1
Independent practice in primary care + Health consultant	1
Employee of a primary care practice + Other in-patient – public health (Post-natal unit)	1
Acute in-patient – public health + Academic (no practice in community-based setting)	1
<b>TOTAL</b>	<b>13 or 36%</b>

#### 5.1.1.5 Current practice setting experience

The length of experience in the current work setting was mostly less than ten years reflecting the recent initiation of the MHNIP and other primary care employment opportunities for mental health nurses. Participants with a longer length of experience in their current work setting were largely those employed in public health facilities or had been in private practice for some time (Figure 12).



**Figure 12:** Participants' years of practice in current work setting

#### **5.1.1.6 Autonomous practice criterion**

One of the criteria for mental health nurses to participate in this study was that they practiced autonomously. There were different interpretations about what constituted autonomous practice. One mental health nurse excluded himself from the study because he worked in a government agency where he interpreted that his practice was ruled by policies and therefore he could not determine what he could or could not do.

Other mental health nurses did not apply this restriction. Their interpretation was that they decided how, when and why they intervened with clients irrespective of the setting in which they worked. One nurse stated that an in-patient setting often had a fixed and conservative culture and so employing certain interventions was discouraged as outside the scope of nurses. Participants reported that one of the motivators for working in the area in which they did was their independence in practice. They were not bound by rigid policies and were free to intervene as they saw fit with their clients, often guided by their clients' expressed needs as the priority in determining their practice.

All mental health nurse participants in this study declared their practice as autonomous as defined in the eligibility criteria for selection (Appendix 4).

### **5.1.1.7 Summary profile of mental health nurse participants**

A purposive sample of mental health nurse participants was targeted who were considered to be able to well inform the study in both breadth and depth about their discipline.

The first criterion for inclusion in this study was that participants are mental health nurses with specialist mental health nursing qualifications and experience. The position taken in this study was that specialist education and training in mental health nursing should be the minimum standard for an adequate workforce.

The standard used was that proclaimed by the Australian College of Mental Health Nurses (2010b) (ACMHN) that a mental health nurse ‘... is a registered nurse who holds a recognised specialist qualification in mental health’. Further, the ACMHN may award a Mental Health Nurse Credential to those nurses who meet the minimum requirements of specialist qualifications in mental health nursing, recent experience, and commitment to ongoing professional development. All mental health nurse participants in this study met the criterion for specialist qualifications and experience which provided a credible profile for practice in mental health nursing.

It was anticipated that a theoretical model of mental health nursing, generated from practice by mental health nurses working in an autonomous way, would be authoritative in terms of legitimatising the identity and scope of practice within a distinct nursing paradigm. All participants claimed, by self-evaluation, autonomous practice. When coupled with their diverse and extensive professional experience, weight is added to their credibility to provide comment on the nature, scope and consequences of the discipline of mental health nursing in all its breadth and depth. Strength is added to this with almost two-thirds of participants having had ten years or more experience in mental health nursing with over half with more than 25 years’ experience.

Participants’ practice experience was also rich in depth as it was across a diverse range of in-patient and community care settings. The greater than average age of participants also indicates practice experience over a long term. As reported in section 2.1.2 of this thesis, the national profile of mental health nurses in Australia records 47.7% over 50 years of age. In this study, 56% of participants were over 50. Similar findings were found in a survey of 238 mental health nurses working in the

MHNIP with the conclusion that this cohort were older and probably more qualified than the general population of mental health nurses (Australian College of Mental Health Nurses Inc 2013c, pp. 20-21).

Approximately 90% of participants practiced in community care settings with two-thirds in the primary care setting. As anticipated in the recruitment of participants (section 2.1.6 in this thesis), the engagement by participants in primary care was largely in the MHNIP (58%). As this program was only initiated in 2007, the uptake by mental health nurses in primary care settings has been recent, evidenced by two-thirds of participants with a length of experience in their current working as less than six (6) years.

It is not contended that participants in this study reflect the profile of mental health nurses in general. The intention of targeting this cohort was to tap a calibre of mental health nurses that had specific qualifications and comprehensive experience in mental health nursing in order to inform the questions in this study with sufficient breadth and depth. It is contended, however, that participants not only satisfied the criteria for participation in this study, but also provide a professional role model for distinctive mental health nursing practice irrespective of the setting in which that practice occurred.

### **5.1.2 Other participants**

Other participants were eligible for participation in this study, namely clients, carers and health care colleagues but only at the invitation of the mental health nurse participant. This strategy was employed in order to comply with section 4.5 of the National Statement on Ethical Conduct in Human Research (Australian Government 2007b). This section provides ethical guidelines for research participants by people with a cognitive impairment, an intellectual disability, or a mental illness. This provided the basis for the special considerations in recruitment of clients as potential participants. In order to minimise the risk to these participants, specific eligibility criteria (Appendix 5), consent forms (Appendix 12) and information sheets (Appendix 15) were developed outlining the safeguards in place.

Participation by this group could be by face-to-face or phone interview or by a brief survey questionnaire. More than one request was made to mental health nurse

participants to invite others to participate. These invitations were through personal requests when mental health participants were interviewed and by follow-up emails. Despite this, there was not a large uptake of this opportunity and only five clients and one health care colleague participated.

Consistent with the commitment made in the ethics application for this research, no other information, other than interview data, was collected from these participants.

#### **5.1.2.1 Client participants**

Three mental health nurse participants facilitated interviews with their clients for this study. Consent forms for this group were signed by both the referring mental health nurse and the client, consistent with the protocol used in this study (Appendix 12).

Three of the five clients were referred by one mental health nurse participant. Two clients preferred to be interviewed at their homes while the others were interviewed at the facility at which the mental health nurse worked. Interviews adhered generally to questions outlined in the interview schedule for these participants (Appendix 7).

#### **5.1.2.2 Health care colleague participant**

Only one health care colleague participated and this was by survey questionnaire (Appendix 9) sent by email, with one subsequent email to clarify some detail in the original survey response submitted.

### **5.2 Initial coding**

When grounded theorists conduct initial coding, we remain open to exploring whatever theoretical possibilities we can discern in the data. This initial step in coding moves us towards later decisions about defining our core conceptual categories. Through comparing data with data, we learn what our research participants view as problematic and begin to treat it analytically (Charmaz 2006, p. 47).

All participant interviews were transcribed and entered as documents into NVivo software for analysis. This involved a total of over 250,000 words for analysis from all interviews. Coding involved reading each of the transcripts line by line and relevant extracts were assigned to a 'node' (NVivo terminology) with a title that reflected the

meaning expressed in the data. As this progressed, extracts from each interview were assigned to an established node, or to a new node if different meanings emerged. At the end of this process, 34 nodes had been identified. These were re-read and collapsed into 13 'parent' nodes with 'children' nodes that expressed a similar or sub-theme, a screen shot of which is attached as Appendix 17.

### **5.3 Constant comparative analysis**

Drawing on Charmaz's views, Urquhart, Lehmann and Myers (2010) reinforce two points about constant comparison of data:

First, making comparisons between data, codes and categories advances conceptual understanding because of the need to expose analytic properties to rigorous scrutiny. Second, it makes the analysis more explicitly theoretical by asking 'What theoretical category are these data an instance of? (pp. 368-369).

As transcriptions of interviews were received and read line by line, relevant extracts around particular issues were cut and pasted into the NVivo software package as nodes labelled with headings depicting their identified theme. Each of these extracts formed a conglomerate of issues raised by the different participants for comparison against each other in the context of the particular theme inherent in each node. The 34 nodes identified were also compared against each other in order to formulate categories at a higher conceptual level.

These data were then re-read and re-framed under headings that were expressed as gerunds. Charmaz, (2006, pp. 135-140) in accord with established grounded theory method, promotes the use of gerunds as they describe actions and connections in the data and aid theorising. The move from coding themes to coding actions, she asserts, aids a process of theorising rather than mere description.

This process resulted in 25 statements that expressed actions and processes of interaction and practice emerging from the data. Reflections and interpretations, and sometimes direct quotes from participants were added to each statement in order to capture the meaning and nuances within the data. These statements formed the platform for subsequent development of conceptual categories, the process of which is described in section 5.6.

This constant comparative process of data analysis was well facilitated by the NVivo software as its database qualities allowed easy and quick access to data across nodes, categories and participants' individual interview transcripts. This gave me the confidence that the relationships within the data were not being lost and could be easily accessed for further exploration.

## **5.4 Memoing and concurrent data generation and collection**

Interviews of participants commenced in April 2012 and continued until November 2012. Over this period, memos were written which consisted of reflective thoughts about the phenomena of interest and other issues that emerged in the data and the research process. As early as the completion of the first two interviews, issues of interest and wonderment about the distinctive characteristics of mental health nurses' impact on positive client outcomes were emerging. A copy of an early memo, as an example, is included as Appendix 18. As interviews progressed, these emergent issues were discussed with subsequent participants at relevant junctures in the interview with them. This served to stimulate thinking on a more conceptual level and/or check out the relevance and significance of emerging issues to the values and practice of the current interviewee.

In addition, throughout this process, Progress Bulletins 1-6 (described in Chapter 4), provided a consolidated synthesis of the emerging issues on which participants were invited to reflect and comment. All Bulletins were sent by email as a blind copy in order to preserve confidentiality. The same Bulletins were sent to other colleagues, national and international, who had expressed an interest in receiving them, by group email. These latter groups were invited to comment if they wished, but their responses were not treated as data for this study as they were not formal participants who had given written consent to participate.

Responses were received from five participants, two of whom gave responses to all six Bulletins and two responded to one Bulletin alone (Progress Bulletin 4). The fifth respondent was not a participant at the time of the response but the Progress Bulletins provided the motivation and inspiration to participate and a formal interview ensued.



## 5.5 Theoretical sampling

Theoretical sampling occurred throughout the interview process by refining questions asked of participants based on interpretations of data from previous interviews.

Participants were recruited progressively over an eight month period in 2012. By the time the first Progress Bulletin was sent, 17 interviews had been undertaken, two of which were with clients of mental health nurse participants. This is reported in the first Bulletin (Figure 3) along with commentary about some data emerging in relation to mental health nursing practice. These interviews stimulated more refined issues to be explored with the subsequent eight participants interviewed up to the publication of the second Bulletin. This Bulletin (Appendix 3) explored interpretations of the way in which mental health nurses relate professionally, and posed questions for comment about the nature of these interactions. Another ten interviews were undertaken in the next three months after which Progress Bulletin 4 was disseminated. The notion of co-construction of care was mooted at this point indicating a progression of conceptual ideas developed from interpretations of the interview data. Bulletins five and six were disseminated after the next seven interviews were conducted over the following two months. These Bulletins explored some special aspects of the interaction between mental health nurses and their clients and began to conceptualise the nature of these interactions and their special or distinctive features. By the end of 2012, 36 mental health nurses and five clients had been interviewed with written data from one health care colleague, 42 participants in all. At this point, no other mental health nurse participants were forthcoming and it was considered that additional data from their perspective would not add significantly to further conceptual development. More data from the perspective of their clients and health care colleagues, it was speculated, could have been useful however this was restricted by the inability to recruit any more of these participants. With this limitation, further refinement of concepts was undertaken and were expressed in Progress Bulletins 8-17 outlining the development of the major and core categories and a tentative grounded theory.

Consistent with grounded theory process, starting with a 'general wonderment' about the phenomenon of interest was preserved until the voice of the participants was

heard and examined. That is, intensive review of the literature did not precede interviews and was engaged as subsequent theoretical sampling. This facilitated a process of de-constructing and re-constructing the initially formulated categories and identified concepts requiring further clarification or expansion. The literature was consulted to fill these gaps and the relevant knowledge obtained was added to the collated data.

In addition, comments from participants on developing concepts, through the Progress Bulletins, were solicited and used as additional data.

These theoretical sampling processes served to build an analysis of the emerging concepts in order to develop them in a more informed and sophisticated way. They were tested with the participants in terms of coherence and relevance to their practice in order to confirm and further refine conceptual development of categories and a core category.

This also needed to be tempered with theoretical sensitivity. This was achieved through constant and consistent self-reflection and supervision, continuing memoing, and critically examining assumptions and biases within the memos against the source data from participants and later, data from the literature.

## **5.6 Category identification**

Conceptual statements, 25 in all, extracted from the initial coding were expressed as gerunds and assigned to fit within the domains of the 'nature', 'scope' and 'consequences' of mental health nursing, consistent with this study's phenomena of interest. During this process, along with reflective and interpretive memos, diagrams of interactional relationships were constructed as catalysts for ongoing conceptual development. Conceptual statements were further analysed in the context of what is distinctive or special about these interactional processes in relation to mental health nursing identity (nature), practice (scope) and outcomes (consequences).

Higher levels of conceptualisation resulted in the 25 statements re-framed as 19 statements, still expressed as gerunds and forming the properties of major categories. Three major categories were developed which, relating to 'nature', 'scope' and 'consequences' respectively were, *'Using the distinct nature of mental health nursing in the service of others'*, *'Working to the edge of practice boundaries*

*with the client*’, and *‘Pulling together collaboratively developed interventions for positive outcomes’*. The sequence and detail of this reduction and refinement of categories is contained in Appendix 19.

The process of consolidating and applying the grounded theory method described and the formulation of conceptual ideas leading to identifying the major categories was spread over 12 months in 2013 and into early 2014. No Progress Bulletins were sent over this period. Therefore, the next set of Bulletins was formulated in quick succession in order to encapsulate the developed concepts. These Bulletins were sent over June 2014. Because of the lapse of time since the production of Progress Bulletin 6 (December 2012), the first of these subsequent Bulletins (Bulletin No 7) provided a summary of the grounded theory method of data analysis emphasising the process of concept formation from data as described by participants. The purpose of this seventh Bulletin was to prime participants to review the following Bulletins with the knowledge that the concepts expressed in the Bulletins were an interpretation of their stories. The aim was to solicit comments that would confirm or challenge conceptual categories in order to further refine or expand them and their properties. Progress Bulletin 7 is attached as Appendix 20.

This Bulletin was accompanied by another that provided the conceptual framework that was developed on the nature, scope and consequences of mental health nursing. This also incorporated the three major categories that were developed and is represented in Figure 13, Progress Bulletin No 8.

# What's Special about Mental Health Nursing? A Grounded Theory study

## *A conceptual framework of the nature, scope and consequences of mental health nursing*

Data from participant interviews were analysed in the context of what is distinctive or special about mental health nursing identity (nature), practice (scope) and outcomes (consequences) to develop the framework below:

From this framework, conceptual categories emerged reflecting the nature, scope and consequences of mental health nursing, described below :



*Regular bulletins will keep you updated with the progress of this research study.*

*For further information, contact the researcher:*

Peter Santangelo on 0438 479392 or by email at:  
psantangelo@bigpond.com

*Chief investigators: Professors Denise Fassett and Nicholas Procter*

**Figure 13:** Progress Bulletin No 8: The nature, scope and consequences of mental health nursing: a conceptual framework

Each of the notions of the special nature, scope and consequences of mental health nursing, under headings of each of the respective major categories, is explored in the following text and in the context of the data emergent from this study.

The concepts explicated are interpretations of the data by me as the researcher. They have been collated through the process of constant comparative analysis and inductively aggregated into concepts representing the interactive process of the phenomena explored. Each of the major categories is interdependent and supports each other to contribute to the development of a core category towards theory generation.

While excerpts of participant data were used in the form of direct quotes, they were not included as definitive statements of the concept explicated. They served to provide the context in which the data was interpreted, examples of statements that have facilitated and contributed to concept generation, and also to acknowledge the participant voice in a direct way.

### **5.6.1 NATURE: Using the distinctive nature of mental health nursing in the service of others**

It is argued that the nature of mental health nursing comprises a number of factors that distinguishes it as special. This category attempts to encompass these factors.

The '*distinctive nature of mental health nursing*' includes one's identity as an individual person, as a member of the nursing profession, and as a person who has chosen specialised education, training and experience in the field of mental health. '*Using*' the '*distinctive nature of mental health nursing*' implies that all of these factors come together as a composite identity in order to practice the art and science of mental health nursing. '*In the service of others*' has the connotation that the purpose of the work is to serve others. '*Others*' most certainly includes clients who are seeking a service, but also may include other professional colleagues, a client's significant '*others*' and in a broader sense, a community.

Nurses are accustomed to being delegated the administration of certain care, for example by medical prescription or referral, which they execute for the benefit of the client in their service to them. The process of negotiating the administration of this care involves the establishment of a workable relationship which is an essential

element of nursing practice. This is not to say that it is unique to nursing however it is argued that nursing brings a particular focus and perspective to the relationship that is founded in its own special discipline as a result of the distinct experience that entails being a nurse, and in particular, a mental health nurse. The factors that underpin the development of this identity and professional persona are explored in the following section and are derived primarily from participants' data.

#### **5.6.1.1. Becoming and being a mental health nurse**

Since the early 20<sup>th</sup> century, the everyday care of patients in psychiatric hospitals has been executed by personnel identified with the nursing profession. As outlined in Chapter 1, the status of mental health nursing, through its growth and development as a profession and a specialty discipline, has elucidated a number of issues in terms of its identity and professional confidence. Proposing that mental health nursing is a discipline that provides a distinctively self-contained contribution to mental health care, still invites debate about its special contribution.

The focus in this study is to conceptualise the lived experience of mental health nursing in terms of its positive attributes and outcomes. The data in this study have been analysed and interpreted to reflect contemporary practice in a particular context as an illustration of mental health nursing practice that is special and productive. Its roots in its history, values and attributes are potent considerations for this inquiry.

Almost two thirds of the mental health nursing participants in this study commenced their training in hospital-based programs prior to nursing education being provided in the tertiary education sector as comprehensive nursing courses. Over three-quarters of participants reported that they had had experience in an acute in-patient setting. Indeed, participants cited this experience as being influential in the development of their current practice as a mental health nurse. For example, many referred to the experience of working in these settings very early in their career. They describe, as impressionable young people, being exposed to extremely disturbed environments where, as nurses, they had to confront and manage these challenges to provide ongoing care. Unlike other disciplines, whose contact with this environment was sporadic and short-lived knowing there were nurses to provide this continuity, they had to deal with it. This experience engendered a distinct capacity to tolerate challenging behaviours, a theme which has emerged from the data in this study.

In the words of one mental health nurse participant:

*"I think the people who become nurses are those sorts of people. I think we're very interested in people. There is very little about people that frighten us; it might frighten us but it doesn't frighten us off. We can go through blood and guts to car accidents, to children with disabilities, to dying, murder and mayhem and we deal with that"* (MHN participant 6).

Accounts in the data are from mental health nurses who have not been frightened off by these confronting experiences. Instead, they have learnt to deal with these encounters and their lived experience of mental health nursing has honed specific skills which include:

- being able to 'be' with people irrespective of their presentation. This engenders an important engagement skill as it conveys acceptance and caring;
- understanding the complexity of issues that confront and confound clients, communicated from the perspective of the client;
- the need and ability to draw on a broad range of strategies in order to assist the client to attain their goals, negotiated on terms that take their (the client's) needs and wishes into account.

Participants reported that having close contact with clients over long periods, for example in acute hospital settings, has sensitised them to seeing the value of persisting with people through their challenging experiences. This builds enduring trust that has a positive impact through that human experience. Sharing interaction over several hours also provides an opportunity to observe, assess and formulate an impression of a client based on the real time experience of being with them. It involves experiencing and interpreting the nuances of those interactions in the context of understanding challenges for clients that mental illnesses and disorders present to them. So it goes beyond understanding illness processes alone to another level of understanding of how that experience is interpreted and responded to by a unique individual.

This interactive experience facilitates learning about what are the important issues for the client at that time. It is proposed that this time extensive and intensive experience is rich in depth and breadth and is afforded to mental health nurses as a result of their idiosyncratic role in providing ongoing care over prolonged contact. It

provides an exclusive perspective in understanding what clients require for productive outcomes.

It is not that other disciplines could not execute their role in this way, but rather that, as a general rule, they do not. These are activities that are nursing in nature and action and have no place or priority in other disciplines. It is purported from this that, while all disciplines interact with clients in various ways, nursing experience, nursing education and nursing philosophy provide a knowledge base and task orientation that is different from other orientations of care. It is also proposed this idiosyncratic mode of interaction provides qualitative aspects that result in a constructive and positive difference for the client in that relationship.

For example, it was common for participants to account that the acute care setting provided the learning ground for a set of skills that is distinctly nursing in orientation. It includes skills of engaging with clients, assessment, total or holistic care, aggression management and generally being with and able to tolerate diverse and challenging behaviours with a level of comfort and confidence that is therapeutic as a result. One participant stated that if she had started her practice as a private practitioner without having had the experience of working with people in an acute setting, this would have changed her way of relating.

*“I would not be as sensitive or intimate or understanding of the challenges that need to be faced and managed” (MHN participant 11).*

Gaining sensitivity, by its nature, requires direct and consistent exposure to the phenomenon or event to which a level of comfort is desired. As well as being exposed to these experiences, mental health nurses need to make sense of them in a way that becomes therapeutically useful and viable. Making therapeutic sense of confrontation with tragedy, distress and trauma in clients induces a process of desensitisation which needs to be interpreted by nurses in a therapeutic context. One participant commented that nurses ...

*“... become sensitised in the way that they are actually able to handle it, they can manage it. They’ve made sense of it, they have processed it” and “... those people operate at a very different level in nursing as therapists, or counsellors or nurse practitioners”.*



However, the same participant contended that this is not a universal quality in mental health nursing:

*“... there are some people who lose their empathy in that. They are not useful in mental health nursing... they’re probably not very useful in nursing full stop”*  
(MHN Participant 6).

The inference made from these reports is that exposure alone is not enough for a positive interactional experience. The response to that encounter becomes therapeutic through intellectual, and by implication of the reference to ‘intimacy’, emotional processing.

The therapeutic qualities developed by nurses through their exposure to these events were also recognised by other professions. It was reported that General Practitioners, for example, would often refer to mental health nurses because they knew they would not be put off by challenging behaviours; they were confident that they would know how to deal with complex and difficult presentations. The one health care colleague (a General Practitioner) who participated in this study described this nursing experience-based phenomenon as follows:

*“Exposure and prolonged exposure in an acute setting presents nurses, in particular because of the amount of exposure, to how individual clients can be in their presentations and how universal interventions are not always useful because of this idiosyncratic response. It also facilitates understanding nuances in client behaviours and therefore an acute ability to be sensitive to and identify the level of risk”* (HCC participant 1).

As well as the experience of working in acute settings, other attributes of the professional development as a mental health nurse were expressed. While participants generally did not refer to their practice as related to particular theoretical models, identifying with models of care tended to come with increasing experience after graduation when they were seeking or came across different models of care. Many of these were around specific therapies or therapeutic interventions, such as psychodynamic approaches, family therapy, acceptance and commitment therapy, Gestalt therapy and the like.

Nevertheless, as cautioned by one participant, not all nurses develop these skills:

*“The ability to construct therapeutic strategies and interventions does not come naturally to many clinicians, especially nurses who follow a predefined script. This is because this ability needs to be honed over time and built on with learning. This is where current practice falls short”* (MHN participant 11).

Consolidated practice of mental health nursing for participants in this study evolved from basic training and experience and progressed, through targeted education, to more sophisticated practice, prompted by their perceived need for more specific and focused knowledge. A contemporary model of how mental health nurses incrementally gain expertise through the scaffolds of clinical development and a framework for learning was developed by Rasmussen and her colleagues (Rasmussen, Henderson & Muir-Cochrane 2014). It provides a conceptual holistic framework regarding the nature of the work of child and adolescent mental health nursing in in-patient units, beginning with state of ‘unknowing’ and culminating to a point of ‘understanding’ and high level of expertise. This latter stage of high expertise acquisition represents participants in this study who considered this level necessary for appropriate specialist and accountable practice.

Reflecting critically on one’s own practice is also essential. One participant reinforced the role of self-reflection on therapeutic interventions:

*“Reflective practices enable a very real and human to human encounter. When I make a positive change in myself, the world around me opens up and changes. And this includes clients who feel/see the possibilities in our interactions and are inspired by that, having hope that they too can change and grow. It’s a very real encounter where I am living and modelling the changes I want to see and not just being an ‘expert’ who prescribes change but doesn’t participate. Clients can see through the latter and are uninspired by that”* (MHN participant 20).

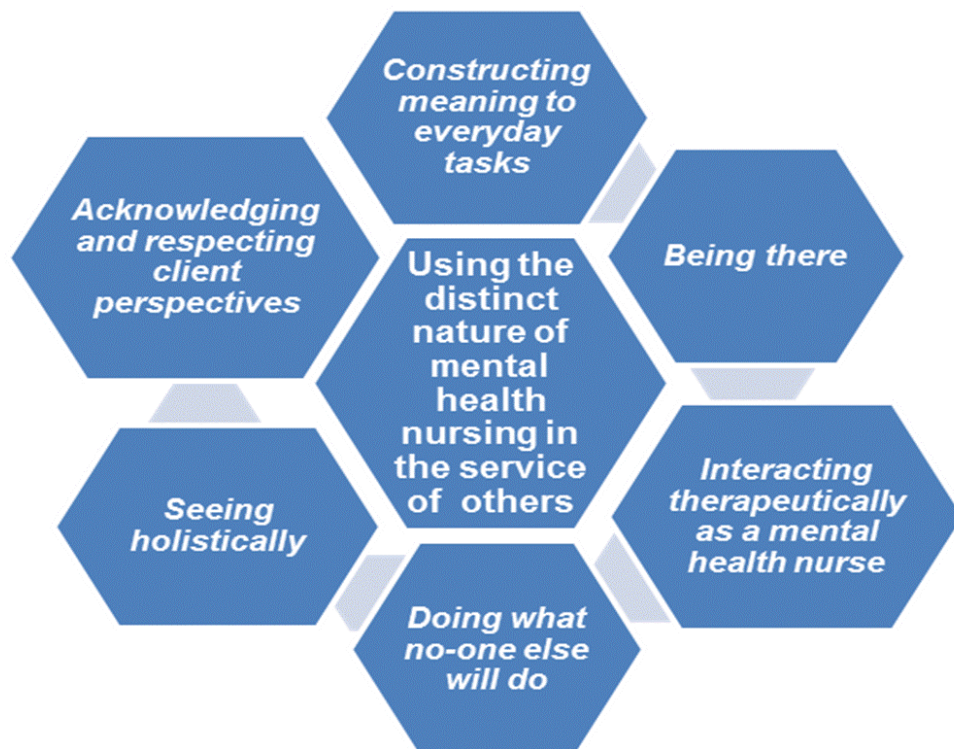
The above example reinforces that the professional encounter by mental health nurses with their clients becomes ‘real’ through a reciprocal human contact. It involves the mental health nurse not merely being exposed to their client’s situations, but also being prepared to expose their human self in that process, motivated by therapeutic intent, inspiring hope and promoting aspirations towards change through participation. Becoming and being a mental health nurse relies on the lived

experience of doing this nursing work and provides a distinct orientation to care because of it.

The category in relation to the nature of mental health nursing explicates its distinct characteristics consolidated through the process of becoming and being a mental health nurse. It makes special reference to the influence of the 'service' aspects of that development and the way this has been adapted towards professional therapeutic benefit for those they serve. This central concept of the nature of mental health nursing, expressed in the title of this category, is supported by its special properties and is represented graphically in Figure 14, Progress Bulletin No 9.

## What's Special about Mental Health Nursing? A Grounded Theory study

*Using the distinct nature of mental health  
nursing in the service of others: An  
explanatory category and its properties*



*Mental health nurses engage holistic care and understand 'the individual as a unitary whole in mutual process with the environment'*

(Zahourek 2008)

*Regular bulletins will keep you updated with  
the progress of this research study.  
For further information, contact the researcher:*

Peter Santangelo on 0438 479392 or by email at:  
[psantangelo@bigpond.com](mailto:psantangelo@bigpond.com)

*Chief investigators:* Professors Denise Fassett and Nicholas Procter

**Figure 14:** Progress Bulletin No 9: Special properties of the nature of mental health nursing

In order to examine this major category in more detail, its properties are explained in the following sections.

#### **5.6.1.2 Constructing meaning to everyday tasks**

Part of the role and expectation of nurses is to assist their clients with everyday tasks when they are unable to do these for themselves, for example, bathing or eating. Some of these tasks could be executed by anyone as they require only very basic skills below that expected of professional education and training. Other disciplines would not see this as part of their remit unless they were within their professional skill set. For example, the primary goals of Occupational Therapists are to promote health and well-being through occupation to enable people to participate in the activities of everyday life (Occupational Therapy Australia 2014). It is imagined that this would involve engaging in everyday activities applying targeted interventions, based on specific education and training, for positive life skill outcomes for the client. Other tasks, beyond the remit of acquired skills through particular professional training, would be delegated or left to others.

Mental health nurses, too, have a specific knowledge base that pre-defines the scope of their practice across a bio-psychosocial spectrum. However, it is proposed that these prescriptive expectations of care delivery do not confine them to a limited range of activities. They are used to being delegated the overall care of clients and engage in activities as a response to the need of the client at the time, many of which may not be anticipated in advance. So while a task may demand less skilled intervention, the execution of that task is not delegated elsewhere by mental health nurses but rather is given meaning based on the potential beneficial outcomes they perceive and know are derived by such activities, such as enhancing client confidence and skills and hope for the future. This suggests nurses generate a different interpretation of such tasks and bring something special in the execution of them with a focus and intent on a therapeutic outcome. Therefore, while the task itself may need little skill or training to execute, the act of therapeutically engaging in such tasks has real meaning and requires a special perspective of what constitutes appropriate care. This is illustrated by the following reference from one mental health nurse participant:

*“It kind of sounds like a mundane thing I suppose, going shopping for a bra because this lady needs that, if you just look at it as a shopping thing. But I suppose it’s the use of the mundane to become something extremely meaningful, and therapeutic. So if you are working as a counsellor in private practice, depending on their work load and sessions, they might not be able to do that. It takes nurses to do that. Yes, I think so, it’s in our program and our role” (MHN participant 20).*

The willingness of mental health nurses to engage in these ordinary activities is a distinct contribution which yields positive outcomes on a number of levels and is claimed as inherent in what they do as nurses. Another participant expressed the nature of nursing interaction when completing everyday tasks:

*“I think the intimacy of what we do - we touch, we handle, we go into both emotional and physical places in a caring way. We don’t do it to intrude or understand them like a specimen under a microscope. We do it to care and soothe and look after someone. The same way as if I’m, you know, washing a patient that I might be assessing at the same time, but I will wash and clean and soothe, hopefully, at the same time. That was how I was taught to be a nurse” (MHN participant 18).*

For mental health nursing, the prescribed roles of ‘nursing care’ provide the opportunity to intervene on a number of levels, often unforeseen and spontaneous. Meaning is generated by and within this intimate interaction and is unique to that episode of care. For the client, the therapeutic benefit can include better levels of functioning, or psychological and social benefits such as successful social engagement, or functional achievement and enhancing self-esteem. It is posited that mental health nurses have rehearsed these ‘professional’ activities time and time again so are confident about the benefits such engagement may bring.

### **5.6.1.3 Being there**

Just being with someone is a role assigned to mental health nurses and to which they have become accustomed. They have experienced this working in hospitals and are prepared to take whatever time to ensure that a client is safe, secure and

supported. This role provides an opportunity to be more than a custodial one to one that generates active therapeutic outcomes.

Case examples from the data demonstrate this. One such case example is included as Appendix 21. It relates gentle, measured and sensitive interventions of varying intensity, catered to the client's readiness for change, over two and a half years and with a positive outcome. Just being present, often over a long haul, can be therapeutic and leads to other interventions that promote growth and independence in the client. It involves working with and working through uncertainty, taking whatever time and collaboration is needed. Nurses mould their interventions to fit the diversity of needs with which the client presents. Being in the moment with the client and responding to clients' cues guide and adapt practice.

This represents a fluid and reciprocal dynamic in therapy that is based on individual needs, presentation, and /or response to intervention. It is not a random event but a response to the inherent characteristics of nursing that is based on serving others in a caring and soothing manner.

*"There is something about the way we deal with patients' experiences as nurses, that is about assessing and gathering data in order to make diagnoses or contribute to the treatment plan and so forth. But it's also simply about providing something immediate for them, being with them in their immediate situation ...about providing comfort and support in those times as best you can. It's something I was taught, it is something that is distinctly nursing. Just being with people is an absolute privilege at those times, and sometimes we have to be with them and be quite firm or intervene and cause discomfort, but there is something about the way we do it that's intimate and compassionate and lets them know that we're there with them." (MHN participant 18).*

This participant refers to these interventions as 'simple' which has the connotation that there is nothing sophisticated about them. This appears to take for granted those inherent nursing skills that have become so familiar and a natural part of doing nursing work. Nevertheless, their impact is profound, illustrated by this report:

*"And I find, sometimes you think you are not actually doing anything much because this particular lady, and the other one that I mentioned earlier, are*

*very negative, very pessimistic, very dismissive angry people and my way of working is to just keep pegging away basically. I just keep going back and gradually worm my way in, and I see myself as probably someone who, unlike anyone else in their life, is consistent. I just keep coming back, I'm the same every time and I'm non-judgmental. And I think that that has been more important in that therapeutic relationship than anything else that I could be doing. Sometimes I struggle that I might not be doing some whizz-bang, you-beaut therapy, but in actual fact I'm doing something that is really useful and that the patient finds useful and I know that it's working. Being with them!"* (MHN participant 5).

Reports from client participants reinforced that having access to a nurse can open doors for them as they (the nurse) have the contacts, medical and other, and can co-ordinate and facilitate whatever help they need whenever they need it. The mental health nurse is working for the client, providing an anchor for them, representing a consistently stable element in their disrupted lives which goes beyond just a focus on illness. Knowing that this service is available is important for clients as is the knowledge that the mental health nurse will be there when they need them. One client expressed this as follows:

*"I saw a psychiatrist when I had my first bout of depression and when I saw him, he medicated me but there was no back up behind that. It's not so much having that theoretical knowledge of what mental illness is, it's more just to have somebody who is on an even keel, who is on your side. It is not a nice thing when you think that okay, people just thinks she's crazy, just dull her down with medication. You need something to go hand in hand with it. But she's (the mental health nurse) made it easy right from the start. Just like being a friend. She's never judged me, she believed everything that came out of my mouth, I could have been sitting there telling a pack of lies but she believed in me. The thing is too, when I sit here and talk to her and get those things off my chest, I can see things more clearly. That's the worst part with bi-polar – any sort of mental thing like that – you do feel isolated. I feel like I've got someone on my side."* (Client participant 5).



In this account, the mental health nurse is not only present, but is there 'just like ... a friend'. This brings a different dimension to a professional relationship where the intention by the mental health nurse is therapeutic in a professional sense but appears to the client as the gesture of a friend. The act of being with someone when they need support, responding to their needs in the moment, doing ordinary things with them and for them, is not perceived as a detached clinical task, but a human response that has significant meaning. 'Being there' for people is what mental health nurses do and allowed to do as part of the expectation of that specialist discipline. It is in their 'program'; the nature of nursing that has socialised mental health nurses to know how to relate in ordinary and normalising ways that also have therapeutic intent, without compromising the human aspects of the interaction.

#### **5.6.1.4 Interacting therapeutically as a mental health nurse**

All professional disciplines interact with clients and one would assume they do that in a way that has the client's best interest at heart. The aforementioned issues conceptualise what may be distinctive about mental health nursing interaction. Interpretations from the study data suggest that there are aspects to that interaction that come from nursing experience, nursing education and nursing philosophy that makes a qualitatively positive difference for the client in that relationship.

Mental health nurse participants in this study recount their interaction with clients, through the various experiences they have across a number of settings, as engagement at the client level. Mental health nursing is not primarily about administering procedures, it is about the relationship; relating intimately and naturally. Of priority is understanding the person, being sensitive to their situation, and being humble in service to them and using their privileged position, emotionally and functionally, to support their clients to get to that point themselves. The notion of humility is viewed by Cleary, Walter and Hungerford (2014) as important in the implementation of recovery-oriented services. Its pursuit and demonstration by mental health nurses, they assert, allows them 'to realistically reflect on their capacity to contribute as well as to value the contributions of others' (p. 112).

It is argued that inherent in the nature of mental health nursing is the close alignment to the clients they serve. This closeness has been engendered through enduring contact where this temporal exposure, this measured time, has allowed an

interaction and understanding of people for whom they care in a way not afforded to other professional disciplines. Experience in spending a lot of time with clients allows the time needed to suss out<sup>13</sup> each other which can then determine how collaborative the relationship will be and therefore how cooperative and productive. Mental health nurses have become familiar with this process in order to achieve meaningful engagement and consequently intervene therapeutically. They depend on co-construction of the relationship in order to do this, both parties needing to be genuine and willing. Part of the conceptual interpretation in this category utilises the notion of 'contract'. This is akin to a legal contractual relationship which, by definition, only exists if there is an 'offer' by the giver and an 'acceptance' by the receiver<sup>14</sup>. The provision of a service by a mental health nurse is delivered with the sense that, as a negotiated relationship, it is the right of the recipient to receive such a service. The nurse has a responsibility to provide a service, and the type of service provided is based on agreement and acceptance by both parties. So there is no room in this relationship for a one-sided approach where the giver will provide what they think is best, irrespective of the wishes of the receiver. Similarly, the receiver, if they want the relationship, will not dictate the provision of a service that is beyond the scope, capacity or ethics of the giver.

This of course assumes that those involved are competent in making these arrangements. For example, in practice there are exceptions where, for example, a person is deemed incapable of making rational decisions for reasons of mental illness or disorder. Even so, nurses do have the responsibility of providing ongoing care to clients even when they are acutely unwell. Given these challenges, the premise of providing care, particularly ongoing care, assumes a relationship that is negotiated. It is argued in this thesis that the very nature of mental health nursing work entails negotiating the terms of agreements so that the work can occur based on agreed and mutual goals.

Achieving that with severely disabled or disturbed people is a distinctive skill that is aided by being a mental health nurse. It is not only time exposure that makes the difference, it is the nature of nursing work; work that is assigned to and adopted by

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<sup>13</sup> A colloquial term defined by the Macquarie Dictionary as 'to investigate directly, especially in a situation involving a particular challenge or presenting probable difficulties' (6<sup>th</sup> edition 2013, p. 1479).

<sup>14</sup> The Macquarie International English Dictionary defines a contract in law as a proposal or offer leading to a binding contract which only exists if that proposal or offer is accepted (2004, p. 1306).

the discipline to provide care, protection and comfort in a period when clients are most vulnerable. For mental health nursing, it involves attending to clients across all their bio-psychosocial-cultural and spiritual needs.

Foundational knowledge in the biosciences puts nurses in a prime position to identify and monitor physical health issues and their biomedical treatments and this intervention may, at times, take precedent over other interventions:

*“I think a reduction of symptoms is important. I’ve got someone who is bipolar on my case load. When he was very low for a protracted period, he was tearful and having thoughts of suicide because he sees no hope in his life. Then I concentrate on that because that’s the severity of symptoms that we have to prioritise. It’s not really about the meaning in his life because I know that he’s presenting like that to me because nothings feels good” (MHN participant 13).*

Being alert to disruptions in health, that are biologically based, is fundamental to nursing and must be attended. However, nurses are also acculturated<sup>15</sup> towards a holistic approach. Mental health nurses, in particular, attend to issues and challenges to life, not just illness. They know, through their prolonged contact and engagement with clients, about what matters in their clients’ lives as they take the time to be with them wherever they are physically, socially, culturally, emotionally and/or spiritually.

The genesis of this orientation to care is derived in part from experience in acute in-patient settings. The challenges in these settings facilitate the ability to tolerate risk and anxiety, allowing mental health nurses to accept the client just as they are at that time, and therefore go on to develop a therapeutic relationship.

In other settings, seeing people in their homes, on their territory, their personal and private space, provides a more intimate understanding of the clients’ relations with others and the social and cultural environment around them. This exposure confronts nurses with a diversity of factors to be considered in determining how they can assist their clients with their life issues. Nurses are accustomed to being exposed to

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<sup>15</sup> The term ‘acculturated’ is use deliberately in this context. More than ‘enculturation’, nursing experience does not just involve being socialised by other influences or cultures of care, but adopts and re-frames other cultures of care (including those of their clients) and re-interprets these in a nursing context as part of its professional evolution.

situations of uncertainty and are able to sensitise themselves to making those encounters therapeutic ones.

*“With the right support and care, people can pull themselves out of the swamp and get their lives back together, appreciating that people with significant mental health problems have a difficult life and can’t maintain some of the stable factors that healthy people do. Clients expose me to stuff and I expose them to stuff. For me, it’s about assisting people either to achieve and reach for something far greater if they are motivated to do so, or allowing them to sit with the limitations that significant mental health issues bring, without having to solve it. You know, living with uncertainty. How we work is embedded in nursing. Just the word ‘nurse’ means that ability to care. Somehow I don’t think we’ve lost that and it’s still a very important part of what we do”* (MHN participant 13).

A significant factor in engaging therapeutically is being able to gauge what needs to be done when and at what pace the client can handle. It is not a pre-determined interaction, but one that is a product of the reciprocal nature of the interaction, each party making meaning from it, in accord with notions of symbolic interactionism. Participants in this study related that the object of their relationship with clients was to help them discover meaning in their lives that accords with their client’s existing or aspirational values.

*“I look at helping the person recognise their own self-worth; the value that they have, the goodness that they have in their life and the good things that they do. I’m also moving them to a state where they are really independent for their own health care as much as possible. Trying to have the patient be as responsible as they can for their own lives, and that’s the physical health, mental health, work, social life; that they have some meaning in their life and being able to see the value of themselves”* (MHN participant 27).

This interaction goes beyond the bio-psychosocial into the spiritual domain of their role, not expressed in theological terms by participants, but in existential terms as portrayed in the account above. The therapeutic intent is facilitated by the nature and intimacy of the relationship. In my Master of Nursing research study, I identified a concept which I called ‘therapeutic intimacy’. The ‘therapeutic’ aspect of this

concept referred to the purpose of the interventions as enhancing or facilitating health. The notion of 'intimacy' denoted the intensity or closeness of the therapeutic relationship characterised by caring and nurturing, power sharing and empowerment, and close contact with all aspects of the client's life. It was posited that this relationship transcended the purpose of just giving therapy but was an integral part of the therapy itself (Santangelo 1996, p. 97). In that study, I also aligned this with Hunt's (1991) quality of 'ordinariness' exercised by mental health nurses which he viewed as a skill distinctively nursing in nature and which provides companionship to others as they live through their experience of illness and distress, a notion not dissimilar to that of 'friend'.

At approximately the same time, although I was not aware of it, Kadner (1994) was writing about therapeutic intimacy in nursing. She referred to a preceding literature on intimacy that indicated its high correlation with positive health outcomes. She proposed that nurses' more frequent accessibility to clients created conditions that encouraged intimacy which she suggested was the phenomenon described as developing a therapeutic relationship. Other authors were also commenting on this phenomenon. A 2001 literature review concluded that intimacy in nursing was ill-defined in nature and called for more research in this area (Williams 2001). A relationship of 'intense professional intimacy' emerged in a grounded theory study of mental health nurses working in remote areas of Australia (Gibb 2003). An ethnographic study explored the phenomenon of mental health nurses balancing intimacy and distance in their therapeutic relationships with clients (Hem & Heggen 2003) and a sociological study revealed that 'over-involved' or 'intimate' relationship with clients was not welcomed by nurses (Dowling 2006). Kirk (2007, p. 233) uses the term 'clinical intimacy' and suggests that the 'mutual construction of meaning in the interactive process between nurses and patients is seen to lie at the heart of clinical intimacy as a hermeneutic<sup>16</sup> enterprise'. And most recently it is asserted that despite the theoretical discussion on the positive effects of intimacy on client care by nurses, 'there appears to be a lack of conceptual clarity from a nursing perspective and little published research investigating intimacy in practice' (Stavropoulou et al. 2012, p. 479).

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<sup>16</sup> Hermeneutics is an approach to the analysis of texts that stresses how prior understandings and prejudices shape the interpretive process (Denzin & Lincoln 2011, p. 16).

Nevertheless, the concept of therapeutic intimacy is identified again in this study as a potent and inevitable factor of therapeutic engagement. One participant expressed it in the following way:

*“I consistently come to the therapeutic encounter with an understanding that there is a transmission of affect that resonates with the patient’s state of mind to mine, although I am willing to not ‘know’ what exactly that might mean”*  
(MHN participant 03).

This acknowledges that the nature of the work induces an emotional connection which is open to further exploration, or not. Nevertheless, a preparedness to allow this experience to emerge requires a familiarity and comfort with sitting in that intimate space, at times contemplating what the experience is like for both parties in the relationship, as expressed in this account:

*“Experiences of trauma have an impact on their personality and I think: What might that be like, the experience of that? How does that impact on their perception of the world and the meaning that they make of even the interaction I might be having with them?”* (MHN participant 22).

The process of interacting therapeutically involves mental health nurses sitting with uncertainty while facilitating emotional expression and having faith in the client’s ability to self-heal through finding meaning in their life.

*“The case of Ms B demonstrates how an openness to not knowing, to curiosity and contemplation on the real feelings, as opposed to focusing on the enactments of self-harm, has enabled her to become more able to think about herself, at times less dissociated and shattered. It increased her ability to be self-reflective, to show imagination and she is increasingly finding more words to describe her meaning”* (MHN participant 03).

Participants also reported therapeutic outcomes of spiritual knowing.

*“People report less symptoms and I think all of that’s important. But for me, it’s about how much joy and pleasure and meaning they are getting from their lives outside of mental health; those who have found more meaning in their life, who are doing more social things, who are feeling more connected outside of here* (MHN participant 13).

Interpretations of these accounts proposes that the enduring nature of therapeutic relationships into which mental health nurses enter generates a sustainable quality of engagement that serves as a commitment to the relationship with the client at their level. Mental health nurses are prepared to be there for the long haul in the face of uncertain therapeutic goals and difficult clinical challenges. They are also readily accessible to engage in diverse therapeutic activities within their professional and ethical boundaries. These activities are often those distinctly nursing in nature, activities not in the realm of other disciplines.

#### **5.6.1.5 Doing what no-one else will do**

The data have revealed issues related to how nursing work is perceived and how nurses respond to expectations of care delivery. Participants described that they are often in the position of doing work that others will not do, expressed by one mental health nurse as:

*"Mental health nursing is very strongly psychosocial. In the end, a lot of what I do is because no one else will do it" (MHN participant 5).*

The inference of this statement, as interpreted in the context of this study, is that mental health nurses see the breadth of needs that require intervention. They confront these needs as a composite set of challenges that require coordination, focus and prioritising using a broad range of skills. They identify their nursing knowledge, skills and experience as being well-equipped to deal with this and they readily and confidently take on that responsibility as nursing work. Examples from the data are:

- Identifying gaps in care based on a holistic assessment and finding ways to fill the gaps. The motivation for this is that the gap is there and nurses are socialised and conditioned to do what others leave;
- Taking on complex presentations when others have given up or run out of ideas. Nurses are used to taking on the responsibility of care where others leave off and therefore they often manage multi-factorial issues and presentations that are complex and require confidence that these can be worked with;
- When other disciplines have no more to offer, then mental health nursing is often the last resort or backstop.

Expressed by a mental health nurse participant:

*“A nurse’s place is whatever else is not taken. If you look at the ward environment, although the great education experience and everything that it is, your place as a nurse there is to fill in all the gaps. You’re not the doctor, you’re not the social worker, you’re not the patient support officer, you’re not the psychologist, but you have to do all those tasks when that person isn’t there. So you get experience at all these different roles. You have to fill in because, if you’re the person that’s there when all these other people aren’t, you have to adapt”* (MHN participant 24).

While this could be reminiscent of the mental health nurses’ self-perception as being a ‘jack of all trades’ (Crawford, Brown & Majomi 2008), the implication in the data suggests a notion more in line with Hurley’s conception of nurses as ‘multi-skilled’ (Hurley 2009a). This also dovetails with the previous properties discussed above in relation to the nature of mental health nursing which is acculturated to provide whatever care is needed across a whole range of activities that are determined by client need and best outcome. Also, the nature of that work is meaningful to that nurse/client interaction. Of all the other mental health disciplines, it is argued that nurses’ underlying values and attributes make them more reliably accessible for the client and more reliably willing and accepting of that role as part of their nursing professional responsibility and accountability.

Mental health nurse participants realise this responsibility and accountability by engaging in ordinary activities with clients, and they do this with therapeutic intent. This generates a notion that mental health nurses are motivated by what they assess and determine is too hard for the client to do at that time, and as an opportunity to support and model the completion of such tasks for the client. Participants’ data indicate that there does not seem to be any self-consciousness about engaging in such activities or any concerns about professional boundaries, for example, cautions about transference and counter-transference<sup>17</sup>. The sole intent is doing for or doing

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<sup>17</sup> These concepts are derived from a psychoanalytic base. Transference refers to when a person transfers beliefs, feelings, thoughts or behaviours that occurred in the past to the present situation. When this occurs in a therapeutic relationship, the response by the analyst to the client, or to the transference, may induce either strong positive or negative emotions in the analyst which can or may transgress or confound what are perceived as traditional professional or therapeutic boundaries (Cameron, Kapur & Campbell 2005, p. 66; Gallop & O’Brien 2003, pp. 219-221).



with the client those things that matter to them (the client) underpinned by the ethical value of providing benefit. An example is related as follows:

*“My main concern for her at the time was I wanted her to get out of the house, get some fresh air and get some exercise and the only way that I could get her to do that (and she could promise till the cows come home) was to go with her. I find that what I do in my practice a lot is going with them and doing things with people, the first time at least. I’ve got another lady who has schizophrenia, generalised anxiety disorder and diabetes, and because she gets so anxious when she sees people, I’ll go along with her to the dietician so that I can get the dietician to speak in a language that she will understand or I can interpret for her” (MHN participant 5).*

The data also suggest that this willingness to engage in and support clients with these tasks or activities is meaningful for the client in terms of their sense of being respected and valued as a person. It conveys a message that any temporary disability that requires such help is not demeaning, but simply a challenge that needs to be met and worked with. It could be speculated that such engagement is de-stigmatising. Again in the words of HCC participant 1:

*“I can tell if the Mental Health Treatment Plan was developed largely by the mental health nurse. Patients report to me feeling understood as individuals, rather than as a ‘diagnosis’ or fitted into a “box””.*

Doing work that no-one else will do implies relegation of work no-one else wants. While that may sometimes be the case, the connotation intended here is a more positive one. That is, mental health nurses will readily take the challenge of providing care in the face of uncertain outcomes because the care is the priority. This is a common scenario in nursing work and others recognise this and perceive that the client will be in safe hands as a result.

#### **5.6.1.6 Seeing holistically**

Holism is a concept that acknowledges, in human terms, that people are complex and individual beings. Therefore, they need to be viewed as a whole being of interacting parts. Happell et al (2008) draw on Pearson’s philosophical concept that a person is ‘different from and more than the sum of their parts’. They surmise that a

holistic model of care is a 'non-medical philosophy incorporating a physical, mental, and spiritual focus where the emphasis is on the interconnectedness of the person and spiritually binds these aspects together' (p. 43). This concept of holism is broadened to include 'understanding the individual as a unitary whole in mutual process with the environment' (Zahourek 2008, p. 33).

The concept of holism, a radical shift in thinking from that of 'dualism'<sup>18</sup>, is one that has also evolved over the years. The concept of holism has broadened, in a contemporary context, to embrace the paradigm of recovery approaches to care. In an Australian context, a national framework for recovery-oriented services reports that recovery approaches, with its roots in the civil rights movement in the 1970s which encouraged a greater consumer voice, are viewed by the consumer movement as an alternative to the medical model which emphasises pathology, deficits and dependency. While there is no single definition of recovery, central to recovery paradigms are 'hope, self-determination, self-management, empowerment and advocacy. The framework cites that a key concept of recovery is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination'. One of its principle domains is holistic and person-centred care (Australian Health Ministers' Advisory Council 2013b, pp. 16-17). The framework report also defines a holistic approach as one that addresses ...

... a range of factors, including social determinants, that impact on the wellbeing and social inclusion of people experiencing mental health issues and their families, including housing, education, employment, income, isolation and geographic distance, relationships, social connectedness, personal safety, trauma, stigma, discrimination and socioeconomic hardship (p. 26) .

Holistic care is proposed as a desirable model of care for nursing on the basis that nursing involves caring as its foundation which is 'inclusive of the needs of the whole person' (Edward et al. 2011, p. 384).

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<sup>18</sup> The Macquarie Dictionary defines dualism, in a philosophical context, as a 'theory holding that there are two, and only two, basic and irreducible principles, as mind and body'. In a theological context, it defines dualism as supporting 'the belief that that a human being embodies two parts, body and soul' (6<sup>th</sup> Edition 2013, p. 457).

Meleis (2012) makes reference to caring theories that emerged in the 1980s that 'elucidate the act of caring in interactive situations, based on values that honor and respect human capacity, spirituality and dignity, hope, trust, and altruism in giving and receiving care' (p. 171). She draws on the work of Jean Watson and Rosemarie Parse who propose that the process of caring in and of itself is one of transformation for both the client and the nurse and referred to as a process of 'becoming' for both clients and nurses. In assessing caring theories, Meleis proposes that caring is central to nursing and its relationship to clients, supports the human relationship experience which affects and changes both parties in the relationship, and is executed in the moment to meet health challenges that are individually defined and collaborative in its execution (pp. 171-172).

The inference from this is that nursing is different because of its distinct way in which it relates to clients and their diverse needs. The foundational knowledge that supports nurses in this endeavour is also a factor. Nursing has a diverse source of foundational knowledge scientifically. Medical knowledge comes from medicine, psychological and behavioural knowledge comes from psychology, and social knowledge comes from sociology and anthropology and the like. The broad training of mental health nurses, in the physical, psychological, pharmaceutical, sociological, and interpersonal domains puts nurses in a position of advantage in relation to assessing and subsequently intervening in a way that is different from other disciplines' interventions for its global perspective.

In a mental health context, there are many reasons and factors that determine why clients seek help. Having sensitivity to a broad range of possible determinants of health challenges allows for a broad range of explanations and therefore a diverse range of possible interventions. Different disciplines will take an interest in issues specific to their education, training and experience based on their particular knowledge base. Nursing takes an interest in all of these because their foundational knowledge is broad, and necessarily so as they are dealing with the whole person and not just one aspect of their life. Nurses are referred or delegated work based on the assumption they will provide monitoring and continuity of care for the person in terms of their diverse needs. They see the potential for a client's wellbeing by viewing health care through a diversity of lenses. The distinct contribution of nursing is just this, they look at and out for people, seeing them in terms of how they are at

that time, and also in the context of their whole life. This orientation of care allows nurses to not only rely on their own interpretation or perspective of health care needs alone, but also to be prepared to be guided by the client's expertise about their life as a priority to inform this journey.

This concept is derived from interpretations of accounts of mental health nurse participants' practice in this study. They identified closely with the notion of providing holistic care and related this as being distinctively nursing in focus. They reported this in terms of having the ability to become the person that is needed at the time, adapting interventions to whatever the client needs, and responding to this by adopting a variety of roles. Elements of this are expressed by some mental health nurse participants:

*"Well I think nursing encompasses a lot of things. I don't think mental health nursing is clear cut about what it is. I think it is a mixture of everything. It is having the ability to become the person that is needed at the time. So if that is to be a social worker role, then that's what you morph into at the time because you've got the skills and the background and history to be able to do that side of things, as well as then provide the psychological interventions and CBT (Cognitive Behavioural Therapy) or mindfulness, but then as well to morph into a family therapist to be able to provide support for the family. As a mental health nurse you are all of them"* (MHN participant 24).

This is an account from a mental health nurse with considerable skills in diverse areas of interventions. Nevertheless, it also conveys the orientation and commitment required for learning and skills development that a holistic approach demands.

*"...we've continued to work with others and the more I've thought about it the more I've thought that that is strength. I think it's a holistic approach. It's about using whoever or working with whomever. We're looking at what resources will empower people and support people. We look at those practical social support agencies when we're working with people. That also ties in with nursing care plans; looking at what is currently available and what other supports we need to put in place. It's all that methodical looking at the needs of a patient or a client and actually contemplating that in a much broader way than just psychological or just looking at the mental health issues.*

*Automatically embedded in my head is this template (I call it my pizza wheel, all those slices) about physical, social, environmental, work, family, relationships, recreational and ... that's part of our theoretical underpinning; I will inquire about that and that's automatic" (MHN participant 13).*

The foregoing accounts reflect two aspects of the nature of mental health nursing. One is the diverse nature of the discipline demanded of it by diverse and complex needs of clients that need to be met as part of the responsibility of nursing work. The other is the difficulty in articulating, in precise terms, the interventions or characteristics that distinguishes a nursing paradigm because of this diversity and complexity. Nevertheless, it also expresses the willingness and natural tendency to get on with meeting these challenges despite the uncertainty surrounding them. It depicts mental health nurses as open to all encounters with a mission to provide a resolution no matter what, a characteristic firmly rooted in their enculturation and acculturation as nurses.

#### **5.6.1.7 Acknowledging and respecting client perspectives**

Both mental health nurse and client participants reported a mutual relationship developed on a basis that acknowledges the experience and expertise of both parties in the relationship. Part of acknowledging the client's perspective is respecting their experience and knowledge about their health and other issues. A professional, coming from a perspective of 'expert', can cloud the expertise and knowledge the client has about their own issues. Professionally or empirically generated understanding of the issues of priority for intervention can describe and identify health issues and behaviours in a pathological context alone. Claiming the wholesale territory of expertise in mental health and mental illness by one participant only in a relationship perpetuates a paternalistic system that disempowers the expertise of others. Interpretations from this study's data, however, have generated a number of properties in relation to mental health nurses' distinct contribution to client centred care that are in contrast to this paradigm.

Firstly, nurses are more likely to be with the client, often in their space, as their story develops and reveals the whole picture of who they are, where they're at and what they want to achieve in dealing with health challenges. As a consequence of their distinct role, they are placed in a position to be with clients at the basic functional

level of the client's health experience, as participants in the life and recovery across all of their clients' health issues. It is purported that another factor that consolidates this relationship is its closeness and intimacy. It is also speculated that nurses, who have been enculturated as subservient in a professionally paternalistic health system, experience some identification and sympathy with their clients whose voice too is often not heard.

Secondly, this working environment allows nurses to formulate a picture over time, and in real time, rather than pre-judging a situation based on diagnosis and its associated prescribed treatments. Nurses will do everything necessary to provide client-centred care, and over the long haul. They understand that facilitating hope is crucial and that healing is achievable. Nurses require knowledge and expertise across the biological, psychological, social and cultural domains in order to fulfil their role. However, they are not governed by the science of the profession alone, but also by the lived experience of 'being with no matter what'.

Thirdly, this interactive experience involves not only acknowledging the client's perspective; it is actually using this perspective as the driving force for their own professional behaviour. It is being prepared to adjust professional behaviour to suit the client's goals. It proposed that this is a determined nursing-based and generated philosophy and principle that has a significant positive affect on a number of levels. Engagement, trust, commitment, motivation, empowerment, independence, self-esteem and respect are all enhanced through being prepared to support clients in the process of their recovery, using all available skills, knowledge and experience to make it work. The values base in relation to this is expressed by the following mental health nurses:

*"I value the person. I value their right to good care, and I value their right to make their decisions and to be empowered to make their own decisions and to be accepted for where they are at. I also value the contribution of science and research and what that offers in order to empower them to make wise choices"* (MHN participant 17).

*"Yes, absolutely, it's their journey, their story, they are the ones that can put it together and not everybody is ready to do that. But when they are, I think to*

*be able to facilitate that is incredibly empowering to them” (MHN participant 15).*

*“It’s very much our regard for them as a human being and they choose the pathway, they choose the way they want to go. We walk alongside them ... it is all done hand-in-hand” (MHN participant 23).*

Commitment to client-centred care and encouraging client empowerment are central to nursing practice and principles, as claimed by this mental health nurse:

*“Yes that sounds very much like the Nursing Process that I learnt in general nursing and ... what I also do in my own practice. Together with the client, I establish client goals, usually at the beginning of sessions and take into account their strengths alongside these. This is very important to differentiate between me identifying what we focus on compared to the client deciding on this. I have seen other professionals, especially those that favour a more medical model, dictate and decide what direction the work takes. There’s no point in me identifying the goals alone as the client needs to take ownership from the start. I can help each person identify their goals through reflection and clarification of what they’ve said but ultimately they need to decide what’s important to them, whether at the very start or sometime later, and we will work in line with that and at their pace” (MHN participant 20).*

#### **5.6.1.8 A hypothetical construct of what is special about the nature of mental health nursing**

Nursing has been defined as a distinct contributor to health care since the time of Florence Nightingale. It has long since been consolidated in its own statutory regulation and has established specific and accredited curricula for learning. As such it has achieved professional status. The professional title of nursing and its basis for learning and practice has been adopted by those who care for people with mental illnesses and disorders. This poses the question of whether mental health nursing is different in nature from nursing in general.

It is contended in this thesis that mental health nursing has justifiably adopted its professional persona in nursing because it fits the frame of nursing work. However, it is also contended that the nature of that work, and the culture of the setting in which

it is applied, has provided different challenges that generate a specialist application of nursing. The nature of mental illness presentations is different and less defined than physical illnesses and the determinants of mental illnesses are broader in aetiology and require specially developed skills in order to care for persons with such illnesses. Finding the 'special' in the 'specialist' and explaining the phenomenon that is mental health nursing is the aim of this study.

In contemplating the distinct nature of mental health nursing practice, Barker, Reynolds and Stevenson (1997) express the view that ...

... being with and caring with people-in-care is the process which distinguishes nurses from all other health and social care disciplines, and needs to be recognized also as the process that underpins all psychiatric nursing... Concepts such as being with and caring with people are not philosophical irrelevancies, but represent the language and grammar of what actually goes on between nurses and patients when effective caring takes place (pp. 660-661).

They further assert that mental health nursing needs to focus on such areas of practice beyond biomedical paradigms 'in order to survive as a key player in the health care field of the 21<sup>st</sup> century" (pp. 660-661).

Barker's notions of care resonate with the data in this study. Nursing practice comes from knowledge not only brought to it by medicine, psychology, sociology and the like, but by the lived experience of being with their clients through their challenges; an integral process of learning which focuses their attention on the client to adopt whatever strategy is available to ensure the client's needs are met. This distinct intimate and client-focused characteristic of the nursing learning experience augurs well for recovery-focused care.

Notions of nursing care, interpreted and developed in this study, as artful, creative, skilled in managing uncertainty and calculated risk management, and honouring client's personal choices as part of realising a recovery approach are supported by other researchers and commentators previously referred to (Norman & Rylie 2009, p. 1537), (Barker 2009a, p. 8), (Finfgeld-Connett 2008a, pp. 383-384). Other authors and researchers continue to explore ways of operationalising recovery approaches



and mental health nurses' role in this (Hamer, Finlayson & Warren 2014; Hungerford 2014; Hungerford & Richardson 2013; Keogh et al. 2014) .

Graham's (2001) phenomenological study of the nature and meaning of mental health nursing practice and its impact on client care also resonate strongly with the concepts in this study. It's findings suggested that nursing is ...

... characterized by holism, relationship-building, partnership and empowerment', and revealed that 'the aim of nursing was to promote a positive self-concept in clients ... achieved by exploring the lived experience of the client and the nurse through relationship-building processes (p. 335).

The distinct relational nexus mental health nurses have with their clients may also promote a positive identity. Hurley and Lakeman (2011) postulate that 'when education and training enhance the nurse's capacity to be an effective helper, and service users are demonstrably helped, this is likely to strengthen identity as a mental health nurse' (p. 746). The inference from their finding, and consistent in the data in this study, is that the nature of the therapeutic relationship engaged by mental health nurses has a mutual nurse/client benefit. This assumes a very different paradigm from an objective, detached, professional relationship that adopts constrained boundary delineation between the professional person and their client as the most appropriate to therapeutic endeavour in traditional mental health care.

The nature of mental health nursing, as interpreted from participants' data in this study, drives practice that establishes a firm and trusting relationship with their clients. This facilitates the generation of ideas and actions that move towards the implementation of strategies for the outcome the client wants. It has propagated a practice that is flexible and grounded in assisting clients meet their life challenges and not just their health issues. Mental health nurses, as a consequence, engage and give meaning to ordinary activities of living through negotiated and targeted interventions that are professionally and client informed, and pursued with therapeutic intent. They have established their identity based on this experience of care and have moved beyond the confines of bio-medical paradigms to more inclusive ones that relate to the broad spectrum of living.

Further, it is asserted that the nature of the relationship with clients is contractual and characterised by humility and the preparedness to engage interventions and practice

to achieve therapeutic outcomes that are often seen to be beyond or out of the remit of other disciplines. Mental health nurses have been in and learned from the privileged position of being with clients for prolonged periods of care, sensitising them to a broad gamut of health and life challenges with which they have grown accustomed and comfortable. This experience engenders a special relationship with clients and a distinct view of the world of mental health care.

A summary hypothesis about the special nature of mental health nursing was written as Progress Bulletin No 10 (Appendix 22) to inform participants and other interested persons of the study's development. This Bulletin addressed issues of the distinct identity of mental health nurses in terms of its specialist practice and attributes of care it delivers. It emphasised the influence of the 'service to others' aspect of its professional development and its client-focused approach. As with all the Progress Bulletins, it provides a succinct précis of the concepts as they developed from interpretations of the data, a chronicle of the research process, as well as inviting participants and others to contribute to develop and refine the concepts presented.

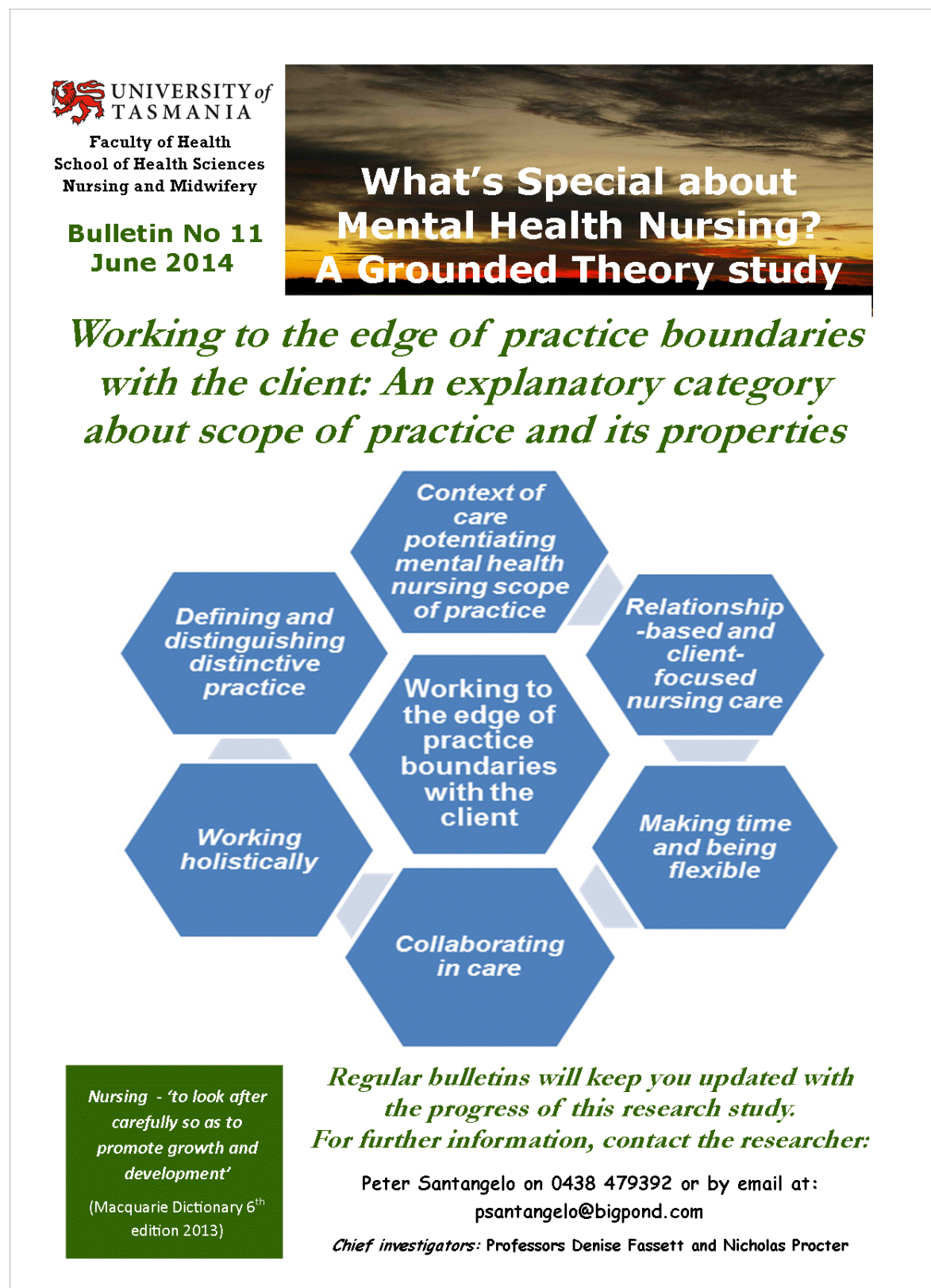
The properties of the nature of mental health nursing, as interpreted from data from participants, provide a foundation that determines the breadth and depth of its practice. The properties supporting this practice are explored in the following section.

### **5.6.2 SCOPE: Working to the edge of practice boundaries with the client**

The conceptual framework of the nature, scope and consequences of mental health nursing in Figure 13 posits that the nature of mental nursing determines its practice. Many of the concepts discussed in the previous section therefore resonate with and, indeed, provide the pre-cursor to practice that is mental health nursing specific. The following properties of the major category 'Working to the edge of practice boundaries with the client', mirror those of the previous major category, aspects of which demonstrate the interrelationship between the two categories.

The category has, as an overarching theme, practice that can be stretched to the limits of its professional boundaries if it is required. The driver for this mode of practice is the commitment to the client as central to the formulation of interventions

that best suit their needs. The properties supporting this category are represented in Figure 15, Progress Bulletin No 11 and are detailed in the following sections.



**Figure 15:** Progress Bulletin No 11: Special properties of the scope of mental health nursing practice

### **5.6.2.1 Context of care potentiating mental health nursing scope of practice**

The setting in which mental health nurses work can determine the scope of their practice. It influences the ways in which they see the world of professional nursing care and how they behave in it. For example, a work setting can place systemic or operational barriers to practice, such as hospital-based work which may inhibit ongoing care where community outreach is not an option. Nevertheless, it does not necessarily preclude mental health nurses, in any setting, from engaging a broad range of interventions that are in the scope of mental health nursing practice and for which they are singly and wholly responsible and accountable.

Approximately 90% of the mental health nurse participants in this study were experienced practitioners working in a community oriented setting of whom two-thirds worked in a primary care context. Practicing in these settings exposed that practice to a broad range of challenges often not encountered in other settings and with fewer bureaucratic restrictions.

The nature of the work in which mental health nurse participants engaged was varied. For example, some had an emphasis on particular psychotherapeutic interventions while others were mostly engaged in case management<sup>19</sup> with people with enduring mental health issues, while others operated with a mix of both. Nevertheless, a common feature for most participants was that they were identified with having particular caring and management skills for people with severe and enduring mental health issues. Often, referral of clients with complex management challenges to mental health nurses was associated with the reputation of their skill in dealing with difficult challenges based on their consolidated experience in acute mental health settings.

This raises the issue of whether the potential of the scope of mental health nursing practice is best demonstrated in this context. In a community and primary care and private practice setting, the bounds of practice are broader and can allow mental health nurses to model practice that has both breadth and depth in its

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<sup>19</sup> While there is no one definition of case management, it is generally understood to involve community-based provision of assessment, planning, linking, monitoring and evaluation of services often targeting people with enduring mental illnesses and disorders in preventive and interventionist ways (Rickwood 2006).

implementation. Also, practicing independently creates different expectations in terms of responsibility and accountability. The Mental Health Nurse Incentive Program (MHNIP) has allowed mental health nurses this opportunity as a program exclusive to this discipline. Working in a primary care setting with general practitioners, for example, has an advantage in terms of client access and opportunities for early intervention. A formal evaluation of the MHNIP adds some support to this which reports that this program enhanced access to care (Australian Government Department of Health and Ageing December 2012).

Having a presence and being accessible to clients when mental health issues first emerge has significant implications for the ability to intervene early. One participant commented that she did not realise how much anxiety people suffered, often in silence, in the community. She observed that this often long-term anxiety is only manifested when it presents in more severe ways, for example by a depressive episode. Identifying other underlying determinants behind the depression then invites an opportunity to intervene in different and more preventative ways. Indeed this also carries with it an ethical if not a professional responsibility to act on issues known to exist and contributing to a presentation of illness or disorder.

Also seeing people in their community context paints a different picture of them. The opportunity to have contact with and see real lives being lived in context, and consequently being challenged to deal with a multitude of needs, invites the mental health nurse to intervene in a way that sensitises them to explore wider possibilities for their clients. Mental health nurses working in the MHNIP report that this program had expanded their role and responsibility and had created an alternative career structure for them in the primary care sector (Australian Government Department of Health and Ageing December 2012, p. 58). This is in contrast to Crawford, Brown and Majomi's (2008) findings that the mental health nurse's role was more blurred in community settings.

The choice was made, for this study, to purposively target and recruit participants working in this context and orientation of care. This was in anticipation that their autonomous and broad scope of practice would yield the greatest breadth and depth of data about mental health nursing practice. Analysis of participant interviews has yielded data that provide an explanation of the properties of mental health nursing in

this context. Interpretation of the data has provided clarity about the distinct contribution mental health nurse participants make and, it is argued, has been enhanced by the setting in which they worked allowing the minimum of constraints on their practice and thereby facilitating the broadest expression of that practice.

### **5.6.2.2 Relationship-based and client-focused nursing care**

Drawing on accounts of mental health nurse participants' past experiences in acute hospital-based services, it is clear that those who have gone to practice more independently and autonomously in other settings have been able to extract the positive aspects of this previous experience. They have discerned what constitutes good role models of mental health nursing, have identified with a client focus early on, are motivated by helping people, and can see hope in the face of hopelessness. As a result of these positive expressions of their previous experiences, they have achieved confident, self-responsible, accountable and autonomous practice in their current work setting. As one mental health nurse put it:

*"Our very role is actually living very closely with the patient or client. You know, we get there at 7.00am in the morning, they're in bed. It may well be that, at a certain point, we deal with their physical needs first. We are able to slip between various roles very easily, we're not sort of compromised just because we've had to take their blood pressure because they have had a funny turn; it doesn't preclude us from being able to sit down and be quite analytical<sup>20</sup>. We're fully engaged with the lived experience of the patient and also the living and the physicality – what it means to live" (MHN participant 6).*

It is clear from this account that mental health nursing practice responds to health needs of their clients, marrying their nursing knowledge and skills about their clients' physical health state, with other acquired skills in psychotherapeutic interventions. Moreover, mental health nurse participants reported employing interventions not necessarily prescribed by an external set of rules or paradigms alone, but by the process of interaction which is catered specifically for that client. This allows the relationship with the client to percolate in order to get a feel for what interventions

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<sup>20</sup> 'Analytical' in the context of this participant's account refers to engaging psychotherapeutically with a client using a psychoanalytic paradigm.

would be most useful and fit with the client. The crucial element in this interaction is acknowledging the client's priorities for care and facilitating their decisions about this.

*"It is the person's choice, for example, if they want to have religion in their life, how they want to live, who they want to live with, what they want to do. Rather than having to insist that they take medication or have treatment, it would be better that they have the decision and authority over their own lives. Of course that does not always happen but it is important that the person has as much choice as they possibly can"* (MHN participant 27).

Mental health nurse participants certainly apportioned the time required for that process to occur. There was not the pressure to make a definitive and prompt decision about the presenting issues in order to move on to some prescribed intervention that fits a diagnostic label. Rather it allowed the development and progression of the therapeutic process and its interventions.

*"All you've got to register with is the individual in the room with you; that individual in the room and what they contribute, saying what they want or don't want, and how you can help them with that. Nurses bring an individual approach to a patient, whereas I don't think psychiatry does; it brings prescription. Nurses can provide that alternate treatment, beyond the drugs. They need a whole variety of approaches"* (MHN participant 11).

This very client-focused and nursing oriented approach assumes that pre-defined and prescribed interventions may not always meet clients' diverse needs. Rather it works with an open pallet, using the experience of the client and the experience of the nurse in a therapeutic alliance that co-constructs the care required to meet the aspirations for a positive outcome acceptable to both parties.

It was gleaned from participants in this study that mental health nurses will go to almost any length to follow through the negotiated goals with their clients and often engage activities that are a means to that end, even if they may be seen to blur the boundary of so-called 'professional' practice. This is coupled and mediated by a very keen ethical principle of always being very careful and mindful to ensure that any activity is for benefit and not harm, while at the same time not being shy to try new and untested interventions. The following mental health nurse's account provides an example:

*“I take her swimming and I just allow her to ventilate what’s going on, we look at different ways of managing her situations. I’ve used swimming with about four or five of my clients who are really depressed so that they can get out and get movement. It’s less strenuous and it’s therapeutic; allowing the emotions to come out. I’m in the water with them all the time. I think: ‘How I am going to teach them or motivate them if I don’t go in with them?’ I feel that it’s not right if I make them go; I’ve got to show that I really do go the whole hog. I would have appreciated if someone had been along side of me when I’ve been going through my periods of ups and downs” (MHN participant 7).*

While this could be deemed to be unprofessional in a conventional or normative sense of professional practice, the above account expresses a clear therapeutic intent, based on a sound ethic of encouraging an activity that will yield benefit, coupled with a tangible demonstration of commitment to modelling healthy activity and interaction. It also demonstrates a willingness of mental health nurses to use personal engagement as an aid to fostering their clients’ use of alternative and healthier ways of dealing with their health and life issues. It is asserted that engaging in such personal activities with clients, where psycho-therapeutic outcomes are the aim, is not common practice among mental health professionals. Although, a qualitative study of social workers working with families where child neglect was an issue, found that many of the therapeutic interventions were characterised by close contact which were friendship-like in nature. It was also acknowledged, however, that working in this way commonly attracted disapproval by professional colleagues (Reimer 2014). Gardner (2010) developed the concept of ‘therapeutic friendliness’ in a constructivist grounded theory study. He purports that this ‘friendly’ approach used by community mental health nurses ...

... is not a contrived approach rather it is genuine friendliness that facilitates an initial connection and allows mutual understanding to develop. It is premised on the following position; you have to have a degree of friendliness in order to first engage the client and then to build the therapeutic relationship (p. 143).

Gardner also cautions that this approach ‘requires a balancing of the therapeutic relationship and professional boundaries’ (p. 140).



This approach to professional relationships is skilful and challenging and requires a sophisticated level of experience and expertise in these unique encounters to affect therapeutic outcomes. The following account refers to some of the complexities involved in this way of relating:

*“As mental health nurse and client, we come together in a shared therapeutic space full of potential. There is mystery in that space as well as relational ingredients ... but at the start of the work we don't know how they will play out. Mental health nursing is all encompassing; it allows me to reach into my full potential, to challenge myself, and in so doing, to show clients and others more of their potential, to work with their strengths and empower them, also consciously revealing some of my own foibles and vulnerabilities at selected times, and in the process allowing clients to learn to accept their own vulnerabilities, integrating both parts in a way that increases inner strength and resources, as well as self-love and meaning” (MHN participant 20).*

This resonates with Finfgeld-Connett's (2008a) work where she states that ...

The practice of 'artful nursing' is relationship centred and involves sensitively adapting care to meet the needs of individual patients, and in the face of uncertainty, the discretionary use of creativity (p. 383).

### **5.6.2.3 Making time and being flexible**

The client participants in this study report that, in their experience, engagement with mental health nurses was different from that with other disciplines. They report that the mental health nurse related at their level and were an equal partner in the therapeutic relationship. They also talked about the two other elements that were important and valued by them in their contact with mental health nurses; time and flexibility.

For the clients interviewed, the 'time' element had three advantageous aspects. Firstly the amount of time a mental health nurse was prepared to give was far more generous than they experienced with other healthcare professionals. Secondly was the frequency and consistency with which they are engaged with the mental health nurse. And thirdly, time was made available outside of scheduled sessions should the client need support.

The other element, 'flexibility', was also significant. Of particular note was the flexibility to be seen at home. This has become a rare commodity with health care delivery and was appreciated by clients when transport, home-bound commitments or social anxiety was a factor. So for some, it was an unexpected facility, it was special, and cherished for its display of respect for and acceptance of them, on their own territory.

Flexibility in how the service was delivered was also valued. Other than home visits and centre-based appointments, sessions could take place anywhere. The deciding factor was what facilitated the best outcome for the client at that time. For example, a visit to the Social Security or Housing Department with the mental health nurse who provided support, advocacy and/or provider networking was not uncommon. Similarly, a walk on the beach, a coffee at a local café with the mental health nurse or the nurse participating directly in an activity being encouraged for the client also occurred as it was required. An example of the latter is one cited earlier of the mental health nurse who reported going swimming with a client who needed encouragement to engage in physical exercise. Another is in the following account:

*"All contacts and their content depend entirely on whether there is a specific issue which needs to be addressed at the time. In fact just a couple of weeks ago, a client came in for an appointment and she said she was sick of therapy and thinking about her thoughts, so we walked around the corner and just had a coffee. She sent me a text the next day to say that was just what she needed"* (MHN participant 05).

Such an activity could be perceived as going beyond accepted or acceptable professional practice boundaries, following impulsive intuitive cues rather than focused, pre-defined and negotiated strategies for intervention. However the perspective of the mental health nurse participants was tolerant of these boundary flexibilities where the intent and strategy was towards doing what was necessary in order to achieve agreed outcomes. Reflecting on planning strategies for a client's well-being, one mental health nurse participant considered that a nursing perspective brought with it different expectations of what is seen to be appropriate practice:

*“There’s no point telling someone and making activity plans – I’ll actually get up and go for a walk around the lake with them. I think mental health nurses put themselves out on a bit of a limb to be more flexible” (MHN participant 24).*

From this practice, mutual benefits are derived. Two of the most valued and satisfying aspects of the work done by the mental health nurse participants in this study was having the opportunity and confidence to practice autonomously, and to witness positive client outcomes as a result. Grounded<sup>21</sup> engagement with clients, time, and flexibility are media which facilitate this work satisfaction. Of significant import is the freedom to practice to the very edges of the boundaries of their discipline in both traditional and creative ways; whatever works for the client. Mental health nurse participants were confident that, when participating in such activities, they maintained their professional boundaries. They were not swayed to moderate these even though some of the activities in which they engaged are outside of the self-imposed professional boundaries and remit of other disciplines. As expressed by one mental health nurse participant:

*“As mental health nurses we are flexible, needs-oriented, client centred, strengths-focused and solution-focused as well. We are looking for meaningful, life changing outcomes rather than restricted ones according to what some expert or administrator has said we need to achieve” (MHN participant 20).*

This is reminiscent of Hurley’s (2009b) work referred to in the preliminary literature review. He purports that the use of the personal self in therapy, time-extended contact, flexibility and versatility in practice and doing practical and everyday activities and interventions distinguishes the practice that is mental health nursing.

#### **5.6.2.4 Collaborating in care**

Collaborative care models are encouraged for system reform (Australian Health Ministers' Conference 2009a) and it is asserted that mental health nurses inherently understand and practice this concept. No one discipline is all knowing about all things. Where clients have a variety of needs, collaboration with a range of available disciplines, each with specific expertise, is essential. This is certainly the case for

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<sup>21</sup> This term is used for its general meaning and not that relating to the methodology used in this study. The Macquarie International English Dictionary (2004, p. 822) defines ‘grounded’ as ‘having a secure feeling of being in touch with reality and personal feelings’ or ‘based on reason, reliable evidence or good sense’.

mental health nursing that has a holistic orientation to care requiring a breadth to its professional thinking.

Notions derived from interpretations of data from participants reinforce the special orientation mental health nurses bring to collaborative care. Mental health nurses are delegated tasks for continuity of care as the 'doers'. They value and rely on teamwork to achieve what they need to do for the client they serve, acknowledging they rely on a diversity of knowledge sourced from different disciplines to meet the multi-factorial needs of their clients. This self-perception as being a cog in a larger wheel is an expectation that is generated from a position of providing for others. Their close partnership with their clients also motivates them to readily take on the responsibility of coordinating care, providing a focal point of advocacy in alliance and alongside their clients as their primary concern. The particular lens that mental health nurses bring to teamwork is illustrated in the following quote:

*"Yes we do very much work in partnership, as a team. I think most nurses have this as a strength because we are used to working within our own team and also with other disciplines. We are "other-minded" in a way that many other professionals are not. I recall going to a workshop many years ago and we were required to get into small groups. One of the other participants was quick to grab a chair without considering the others in the group and it was one of the nurses who looked around, considered the needs of the group, determined we needed more chairs and started organising herself and others to collect and arrange those. It was an act of caring and organised problem solving that I had taken for granted, thinking that everyone thought and acted like that. It stands out in my mind because up to that point, I thought everyone was like-minded in that way and then I realised they weren't" (MHN participant 20).*

This account was stimulated by prompting this particular participant to contemplate what may be different or special about mental health nursing in the context of this study's interests. The action described could be executed by anyone however for this participant, it reflected a revelation born out of feeling or doing something that was different. Extending this experience to thinking about a nursing frame of reference, it was ascribed a distinct characteristic, the concept of being 'other

mindful', that was regarded by this mental health nurse as nursing specific. This single example, of itself, may seem inconsequential in the broader conceptualisation of nursing phenomena. However, in the context of conceptual interpretations reported earlier about the nature of mental health nursing, it represents a composite of attributes, such as a commitment to the service of others, caring to do what others may not, and assuming the responsibility for coordinating action when it is needed. In this way, it lends explanatory power to those elements that are the essence of mental health nursing.

Mental health nurses are good at communicating what it is they are doing with a client because they are used to working in teams. They are also used to the process of clinical handover<sup>22</sup> as an essential communication mechanism for continuity of care. They trust and respect what other disciplines bring to their knowledge as they are used to relying on evidence from other disciplines' science to inform their specialist practice. Having said that, nurses also discern what and how this knowledge will be used in order to suit the particular client and what fits with their own expert knowledge. Nor do nurses need expertise in everything in order to do nursing work. For example, without understanding all the physiological mechanisms in relation to neuroplasticity<sup>23</sup>, they can take the science on trust, given reasonable appraisal and evidence, and can interpret how this provides possibilities for their client's recovery. So, possession of a bit of that trusted knowledge can facilitate nursing work, such as persisting with care and encouraging hope, working in a recovery way, using and teaching helpful techniques such as meditation. Similarly, knowing that physical exercise has beneficial effects for mental health can spur interventions such as going for a walk with the client. Engaging in activities with the client serves as both a motivator and role model for them as well as exploiting the opportunity to relate on an equal level with them. Such interventions can also lend an opportunity to assess, with the client, in the moment, any beneficial outcomes while employing, for example, talk therapies. It is argued therefore that nurses go beyond

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<sup>22</sup> 'Clinical handover' is defined as 'the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis' (Australian Commission on Safety and Quality in Health Care 2010, p. 4).

<sup>23</sup> The Macquarie Dictionary defines neuroplasticity as 'the ability of the brain to change ... in response to experience, such that functions believed ... to be supported only by particular areas of the brain become supported instead by others' (6<sup>th</sup> Edition 2013, p.988).

prescribing such interventions for clients; they are prepared to do them, with them, knowing the benefit in terms of relational and goal-directed outcomes.

This approach to care differs from one that subscribes to conventional bio-medical modalities. A health service culture where the dominant paradigm of care is a medical one will inevitably affect how nurses practice. For nurses, there is a special relationship with a bio-medical model of care. Nursing has developed under the guidance of this paradigm and there has been an interdependent relationship developed between doctors and nurses that is, in the main, complimentary where each discipline's contributions are valued by both. Complimentary does not imply co-dependence, but difference that requires collaborative effort. Medical intervention has a high status professionally in that it is seen to involve technically high levels of skill. Nursing is perceived as highly valued because of its caring and comforting role. The caring and comforting aspects facilitate a tightly bound relationship between mental health nurses and clients in which co-construction of care evolves. As their primary focus is client centred, they learn to manage constraints that they see will inhibit their ability to advocate for the client's best interests. With this close client focus, mental health nurses are also motivated and moved to co-construct care for clients with their medical and other colleagues, probably much more collaboratively in mental health care than in other domains of health care given the multi-factorial determinants of mental health issues beyond clear cut bio-medical determinants.

That is, there is a greater reliance on wider expertise and experience when the challenges faced are not neatly fitted in the realm of one discipline alone. The required contribution of each discipline is that of working as an ensemble rather than independently to which nursing is both accustomed and in which it is well rehearsed.

#### **5.6.2.5 Working holistically**

With reference to mental health nursing practice in a community setting, exploratory studies have identified the concept of holism as fundamental to effective practice (Clark 2004; Long & Baxter 2001).

In a descriptive, exploratory study of mental health nurses practicing in the MHNIP in Australia, Happell, Palmer and Tennent (2010) identified 'a holistic approach' as one of four major themes. They reported providing treatments beyond the limitations of a

focus on psychiatric illness or disorder to one that included a wider social perspective as well as attention to physical ailments which they assert was 'only possible due to the broad health training undertaken by mental health nurses' (pp. 334-335). Approaches that incorporate biological, psychosocial and pharmacological components are also proposed for improved person-centred care and outcomes as well as contributing to mental health nursing practice development (Clarke & Clarke 2014).

This is further reinforced by a critical analysis undertaken of mental health nurses working in the MHNIP. The authors of this analysis conclude that the program, and the mental health nurses within it, are able to address unmet needs of people with a mental illness 'by adopting holistic and consumer-centred approaches and by providing a wide range of therapeutic interventions' (Hurley et al. 2014). The holistic orientation of care, as a positive impact factor on client care is also referred to in other studies and commentary in relation to the MHNIP (Australian College of Mental Health Nurses Inc 2011, 2013c; Happell & Palmer 2010; Happell, Palmer & Tennent 2010; Happell, Platania-Phung & Scott 2013; Lakeman 2013; Meehan & Robertson 2013a, 2013b).

As previously discussed, participant data in this study indicate that a distinguishing feature of the nature of mental health nursing is 'seeing holistically'. Further exploration of the data indicates that this professional lens impacts on practice in a special way. It is purported that mental health nurses are attuned to the lived experience of their clients through their special interaction and therapeutic engagement with them. Participants reported that therapeutic interventions, while bio-psychosocially oriented, are determined foremost by responding to the client's struggles using whatever therapy or intervention is workable for them. Mental health nurses interviewed go beyond evidenced-based practice that is professionally defined to include evidence that is borne in their relationship with the client. They are prepared to accept evidence that informs a positive outcome that is client defined. So it is proposed that the mental health nurse does not merely formulate a holistic assessment of the client's issues objectively, but rather constructs with the client a picture from both their perspectives. This brings to the interaction a willingness by mental health nurses to not only draw from professionally defined and/or evidence-

based practices, but to experiment with practices based on evidence emergent from the interactive process itself.

It is argued that this is in sync with recovery principles; shared goals and aspirations towards a better life that is client driven; a client focus which sits comfortably with a professional paradigm of care based on serving diverse needs. Watson's and Parse's principles of caring "as a process of 'becoming' for both clients and nurses" also rings true in this context (Meleis 2012, pp. 171-172).

#### **5.6.2.6 Defining and distinguishing distinctive practice**

There are statutory and legal limitations to what nurses can do. In the realm of mental health, within these limitations, relation based and psychotherapeutic interventions can take a number of forms and are not subject to clear and definitive regulation. It is proposed that the test of the validity of an intervention is whether it is determined to be ethical (does it do no harm?), legal (is it within the confines of the law?) and professionally practicable (does it benefit the well-being of the client?).

What constitutes professional practice in mental health nursing, in terms of its distinct contribution, is the issue pursued by this research study. Interpretations from participant data have yielded characteristics of mental health nursing that distinguishes practice as peculiar to their education, experience, identity and ethos as a nurse.

The Macquarie International English Dictionary (2004, p.539) defines 'distinct' as 'clearly different and separate from others' and 'strong enough, large enough, or definite enough to be noticed'. 'Distinction' is defined as 'a difference between two or more people or things' and 'distinctive' as 'uniquely characteristic of a person, group or thing'. And further, a 'distinguishing feature' is defined as a 'feature or quality that that characterises or singles out somebody or something'.

The Oxford Paperback Thesaurus (1994, p.216) lists synonyms for 'distinctive' as 'characteristic, typical, particular, peculiar, special, different, uncommon, unusual, remarkable, singular, extraordinary, noteworthy, original, idiosyncratic'.



The notions of 'difference', 'characteristic', 'special', and to some extent 'idiosyncratic'<sup>24</sup> as well as 'being definite enough to be noticed' are core definitions to the thesis in this research study. It is concerned with what is the added value that a nursing lens brings to mental health care delivery and how a nursing ethos determines ways of intervening that are different.

The mental health nursing participants in this study were recruited deliberately to potentially demonstrate an expression of mental health nursing that stretches established or traditional parameters of care in terms of practice, professional boundaries and paradigms of care that may be constrained by some practice settings, but still within accepted professional and ethical boundaries. By exploring the widest possible expression of practice, it is argued that greater is the opportunity to reveal distinctive features of that practice.

Nolan (1993) refers to the limitations that practice settings can bring to the advancement of thinking and development of mental health nursing. Specifically he relates that the culture of mental health nursing in institutional settings has been acquiescent to a medical paradigm and pre-occupied with issues of safety and security. The inference from this is clear. Without a radical change in the ethos of care for the mentally ill, a limited vision of mental health nursing practice is sustained. He writes:

Those who practice as psychiatric nurses are the inheritors of a tradition based on custom and practice which determines their role and self-image and which confers on them the security they need to work with the very sick and the incurable. Theorists have failed to recognise how deeply embedded this tradition is and how valued by psychiatric nurses, hence, how unwilling they are to see it undermined. Theorists gain their security from the advance of ideas; those whom they attempt to influence gain their security from the status quo no matter how unsatisfactory (p. 159).

In addition, Nolan (1993), referring to Altschul's study around interpersonal relationships of nurses and patients in the 1970s, says that she concluded that

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<sup>24</sup> 'Idiosyncratic' is defined by the Macquarie International English Dictionary (2004) as 'a way of behaving, thinking, or feeling that is peculiar to an individual or group, especially an odd or unusual one' (p. 930).

"nurses mainly operated 'lay' or 'common-sense' perceptions of the mentally ill and that it is impossible to uncover any theoretical basis upon which they acted". He also refers to Towell's observations in 1975 that 'psychiatric nurses undertook a variety of roles, but did not ascribe much importance to forming relationships with patients' (pp. 17-18).

This is clearly written in an historical context and from the perspective of the dominant setting for mental health nursing at the time, that is, in an in-patient setting. As early as the 1960s, Peplau (1962a), in contemplating the future role of mental health nurses, was critical of professional nurses taking on 'clerical, receptionist and hostess-type duties' in contrast to, and in her view, the more important role of 'an intense, abiding, and lively interest in the nature and consequences of their direct practices with patients' (p. 17). She also drew a distinction between 'nursing in psychiatric units' and 'psychiatric nursing'. The latter category she describes as 'specialist', achieved by experience and education, and indeed argues that the crux of its practice is interpersonal techniques. She further asserts that 'technical expertise in giving medication or carrying out procedures associated with nursing is ... not the desirable emphasis in psychiatric nursing' (1962b, pp. 50-52).

Peplau's observations, as a theorist, emphasise and support Nolan's report of the dissonance between theory and practice in mental health nursing. While a practice setting may influence the practice within it, it does not define, it is argued, the rightful practice of the discipline as a whole. If that practice setting is dominated by a narrow paradigm of care, this does not and should not define the scope of possibilities for meeting client needs nor define the practice required to meet this challenge. That is, traditional practices should not constrain the evolution of practice that is required to meet contemporary needs.

It must also be acknowledged that what is contemporary is also contextual and temporal. That is, what we understand is based on the context in which it was conceived. In her preface to her book "Interpersonal Relations in Nursing" originally published in 1952, Peplau addresses this by proclaiming that 'all books reflect, to some degree, prevailing or emerging trends coincident with the era in which they were written' and acknowledges that her book is no exception (1991 Location 31 in Kindle version).

So too is the data in this study. The practice of mental health nursing, as described in and interpreted from the data, is in the context of a largely community and primary care setting. This setting exposes the mental health nurses within it to determinants of health issues that are bio-psychosocial in origin which necessitates a broader response. Mental health nurse participants demonstrated that a nursing orientation to care is well suited to administer care in this environment. They engaged, as part of their role, in a variety of activities. They provided physical caring and identified real or potential physical health issues. Often this involved touch, which, as part of administering nursing function, has become an accepted practice without boundary violation. The notion of 'nurse', it is purported, gives and allows proximity to the client in a close and temporal and repeated sense.

*"We are with patients more than other professionals so I think we know more of their needs. Mental health nurses in the MHNIP are also fortunate to be able to work long term with patients so we get a more complete picture and go into a deeper relationship than other professionals who don't work in this way. In the MHNIP we also work with financially disadvantaged clients who are not able to access other professional services because of cost restrictions. And those patients are often very disempowered and in need of an advocate so we naturally take up that role because we're good at it"* (MHN participant 20).

It is argued, therefore, that there are specific domains of mental health nursing care that distinguishes it in service delivery. For example, mental health nursing is grounded in understanding symptomatology and where that fits with the patient and the impact that has on them. Mental health nurses develop skills in managing this, dealing with symptoms and helping clients work through these issues, supporting, soothing, witnessing, and giving treatments for the symptoms combining and emphasising a humanistic as well as a clinical approach.

*"I don't think that other disciplines have had the grounding in some of the solid aspects of caring for symptomatology. For me though, that grounding in understanding symptomatology and where it fits in the world of the patient and the impact it has on them is where I think my skills lie, or nursing skills lie. Delivering care in a way that hopefully is comforting and soothing at the same time as being functional; always being considerate of the person's dignity,*

*feelings, both emotional and physical feelings when you're doing anything. The mental health nurse is more of a person and less of a clinical tool" (MHN participant 18).*

And these activities are invariably combined with psychological and behavioural interventions. One report from a client provides an illustration:

*"Like last week, I must admit, I was (because I've been off my medication) heading up that mountain of going manic and I think M did pick up on it. I was getting pretty irritable and mouthy, I suppose, with M, but she just didn't blink an eyelid. It was like a parent telling a child off but in the end things are never left unsettled. So by the time M left, I'd calmed myself down and we were back on that level playing ground again. You're in your own home too, you're in your own comfort zone. This is my comfort zone which is a lot different to going and sitting in someone's office" (Client participant 5).*

Narrow application of particular interventions can be limiting to nursing practice so flexibility of practice is integral to nursing interventions. An example comes from a mental health nurse who practices within a psychoanalytic paradigm. The nurse explains that psychoanalytic principles dictate rigid boundaries in relation to engagement with clients which prohibit, for example, any personal contact or physical treatment. Nevertheless nurses can and are prepared to employ their nursing frame along with psychoanalytic ones and indeed see this as a professional responsibility.

*"We can't help taking people's temperatures and giving them pills, because it's what we do, you know, the very active acts of nursing, the definition of nursing. To actually nurse somebody is to physically engage with them. When nurses came out of the nurse role and went on to a much more vigorous therapeutic liaison, they had no difficulties. They thought it was remiss of them not to look after the physicality of the patient. The patient didn't find it a problem either because they didn't know the rules of analysis. Now I find myself having to deal with the issues of metabolic syndrome and dietary control and weight stuff and all of those sorts of things. So within an analytic session, I might actually weigh somebody. Everything I do is informed by me as a nurse" (MHN participant 6).*

They also acknowledge biological, psychological and social determinants of health and are therefore prepared to engage in a range of activities with the client and with the aspiration of a therapeutic outcome.

*“To me they work to the edges of the boundaries that have to do with a bio-psychosocial model, with engagement and therapeutic relationships as its core. And I’m not just talking assessment, I’m also talking treatment. I think mental health nurses are best equipped to reach the edges of bio-psychosocial models of care simply because their foundational education emphasises all three of those fairly distinctly”* (MHN participant 14).

It is concluded from these concepts that the variety of health needs with which nurses are confronted demands the application of varying, and often different, interventions to cater for the diverse range of presentations requiring attention. This practice scenario develops knowledge and skills that may not be afforded to other disciplines that do not engage and practice in the same way. Nurses are allowed to have many strings to their bow and they use them in way that is guided by the client, creating a synchronicity between them and the client.

*“Nurses are much less scripted. I think nurses have a little bit of lots of frameworks that you pull in and use as you need to. Going with the flow with that person’s health makes sense to me, because if you can walk with them and do a little bit of CBT here, and then you might do a little bit of motivational interviewing, and a little bit of narrative therapy, and whatever you do along the way, plus just listen to the person as a person. And often it’s just that listening that is useful, without having the next thing in mind”* (MHN participant 15).

Mental health nurses use a flexible approach when implementing specific nursing clinical interventions, such as assessment and health and medication monitoring:

*“I think we’re much better at picking up mental state cues in a non-direct way. I would take patients shopping and when you do those sorts of things you’re always being a mental health nurse. You’re always working and making sure they’re safe. You’re doing assessments, and getting that information and supporting them and all that sort of stuff, but in a way which is perhaps less obvious. I think that’s a skill that we have that I’ve never thought about before,*

*and it's not particularly defined because it's a skill that you get from just walking with someone – side by side” (MHN participant 15).*

It is not just doing the individual tasks, but the engagement with the person's whole life, acknowledging every aspect of it. Mental health nurses deal with the totality of the client, using specific knowledge and skills in a bio-medical sense but also with a social-interpersonal view. They see beyond symptoms and behaviours to envisage what the whole person is like, in what environment and with what resources and capabilities.

They develop the ability and experience to engage with people in a therapeutically intimate way, where they and the client feel comfortable. This is through exposure and rehearsal over time and legitimatised as part of the role of nursing. And the client benefits from being treated as whole by a single person, rather than in bits by different people and this experience, for clients, is distinctively nursing. One mental health nursing participant described distinct nursing orientation to care in the following way:

*“There are certain principals that any health professional could abide by but I guess it's the totality of what you bring to the patient. You bring a relationship that has been established over the last few days, you've done things so you have gained the person's trust, you've done things to help them physically when they were unable to care for themselves. I think it gives us, because of our interactions with patients, privileges that our other professionals don't get. Privileges of openness from patients, of access to them, of being able to do things with them that others couldn't do. That's nurse-patient relationship stuff” (MHN participant 1).*

While reference is made by participants to other disciplines, comparative analysis of mental health nursing with other disciplines is not the intention of this study. It is rather to explore the essence of a mental health nursing orientation of care irrespective of the orientation of other disciplines. Care was taken in interviews to elicit mental health nurse participants' thoughts about the phenomena of interest in this study and to be self-reflective in teasing out those things they believed are distinctive or special about their practice that yielded positive outcomes for the clients they serve. An example of an introduction to an interview is as follows:

*“The questions are asking you to think about people that you see and the sort of interventions that you employ to yield a positive outcome for them, describe some of those outcomes, and how you determine the outcomes are positive. We will also explore on what basis you make decisions to intervene in a certain way, where those interventions come from. At one level, it’s talking about what it is that you do to achieve a positive outcome. On another level, it’s about whether there is something distinctive or special about those interventions that are specific to you as a mental health nurse rather than any other discipline. It’s not about competition between disciplines but it’s about teasing out what maybe special and distinctive about your intervention as a nurse and if this provides a distinctive contribution to positive outcomes for clients”.*

A focus that was an introspective exploration of mental health nursing phenomena was maintained rather than a comparative one between disciplines, which helped separate and discern its distinctive characteristics.

#### **5.6.2.7 A hypothetical construct of what is special about the scope of mental health nursing**

All disciplines employed in the context of mental health care are working with people. It is reasonable to assume that all would claim a definition of their practice that somehow depicts the way in which they relate therapeutically with them. The position this thesis poses is that the breadth and depth of mental health nursing practice provides a distinct therapeutic contribution to the mental health care of their clients.

A medical construction of illness, through medical diagnoses, employs prescribed treatments to which nursing traditionally plays an operational role. Nevertheless, it is also asserted that the scope of mental health nursing practice is determined, not by the prescription of other disciplines, and in particular medicine, but rather by taking cues from a variety of sources.

The mental health nurse participants in this study engaged in autonomous practice in settings that exposed them to diverse physical, psychological and social challenges, which in turn influenced their practice. They engaged interventions based on their knowledge, skill and experience in this diverse range of challenges to provide

integrated bio-psychosocial care. They identified strongly and positively with nursing as a discipline and accepted the sole responsibility and accountability for their distinct practice. They were also prepared, within the constraints of statutory limitations of their role, to practice to the very boundaries of that role in order to meet their professional and ethical responsibilities. As such, they provide an exemplar of both the potential and realisation of mental health nursing practice.

Therefore, it is proposed that mental health nursing, as exhibited by this study's participants, is special in a number of ways. Nurses are delegated or referred the care of clients who are compromised by health issues in some way. Their practice involves direct ministering of care that is not relegated into the physical, psychological, social and spiritual domains in isolation, but as a deliberate and coordinated collective of care imperatives. It is argued that this perspective of care is quintessentially nursing, related to its holistic world view. This particular perspective drives practice that seeks solutions in the broadest way, facilitating the range of resources required to achieve resolution of client needs through negotiation and collaboration.

In order to achieve these practice goals, mental health nurses rely on the relationship negotiated with their clients for a therapeutic outcome. They also rely on the client's contribution in communicating their needs and negotiating, in partnership, the nature and execution of interventions to meet them. In this way, the relationship is a co-construction of the professional aspirations (for the nurse) and the personal aspirations (for the client), in harmony. This engenders a different interpretation of the notion of 'client-focused' care. More than considering the client as the focus of care of which they are recipients from others, it depends on them to generate and affect that care as a partner in the process. Using clients' direction to facilitate care is, in a real sense, in accord with recovery approaches to care.

It is concluded from these notions that mental health nurses are professionally attuned to play out their role in these ways because they are accustomed to and comfortable with close and enduring relationships with clients. The privilege of this intimacy is founded in nursing experience and affords a coupling in care that is woven into their professional *modus operandi* and is distinct as a result. The bounds of their professional practice are not determined by their education and training



alone, but by the ethos and experience of care this peculiar orientation provides. It allows flexibility and breadth in practice that is extraordinary.

The distinct contribution that mental health nurses provide to care is acknowledged and appreciated by their clients for its inclusiveness, humility and respect for their capabilities. It is also recognised by other health colleagues who work closely with them for its specific skills and effective complement to their care. In providing a different and productive perspective, the mental health nursing contribution is also essential.

Progress Bulletin No 12 (Appendix 23) presents a synthesis of the above hypothesis. It depicts mental health nursing as a self-determined discipline incorporating a broad range of knowledge that translates to practice that is holistic in its perspective. It further builds on the concept of co-construction, first introduced in Progress Bulletin No 4 (Appendix 3), characterised by collaborative partnerships that are intimate and humble in their execution which brings the notion of client centredness to a new level.

The distinct nature and scope of mental health nursing practice serves to achieve the ultimate goal and responsibility of all health care disciplines, that is, effective outcomes as a consequence of their contribution. The following section addresses this issue in relation to mental health nursing.

### **5.6.3 CONSEQUENCES: Pulling together collaboratively developed interventions for positive outcomes**

The ultimate test of effective care is positive and productive outcomes for the recipients of that care. As expounded so far, it is posited that the nature of mental health nursing determines its scope of practice which in turn affects outcomes that are facilitated because of this distinct application of care.

The consequences of mental health nursing practice are expressed in this category as positive outcomes for the clients they serve. It explicates properties that result in a mutual benefit for both the nurse and the client from their special interactional experience. Its properties, detailed in the following sections, distinguish mental health nursing input and are represented diagrammatically in Figure 16, Progress Bulletin No 13.

## What's Special about Mental Health Nursing? A Grounded Theory study

*Pulling together collaboratively developed  
interventions for positive outcomes: An  
explanatory category and its properties*



*'Evidence-informed practice' promotes the collection, interpretation and integration of valid, important and applicable patient-reported, clinician-observed and research-derived evidence.*

(McKenna, 2009)

*Regular bulletins will keep you updated with  
the progress of this research study.  
For further information, contact the researcher:*

Peter Santangelo on 0438 479392 or by email at:  
[psantangelo@bigpond.com](mailto:psantangelo@bigpond.com)

*Chief investigators:* Professors Denise Fassett and Nicholas Procter

**Figure 16:** Progress Bulletin No 13: Special properties of the consequences of mental health nursing practice

This category explains the product of mental health nursing as a consequence of its special nature and practice and intricately interrelates with the previous categories to build a composite picture of mental health nursing nature, scope and consequences.

#### **5.6.3.1 Determining appropriate outcomes through partnering**

One of the core interests in this study is the distinct contribution that mental health nursing, as a discipline, has on positive outcomes for clients. As a catalyst to discover what is useful and perhaps peculiar to this discipline in this regard, this study assumed a strengths-based approach by focusing on mental health nursing actions that have a positive result. The focus was therefore more on mental health nursing behaviours. That is, the emphasis was on the process of mental health nursing practice rather than a validation or evaluation of the outcomes themselves. To that end, in the course of interviews, the positive outcomes claimed were taken at face value and the processes affecting that care examined.

Mental health nurse participants revealed that practices which resulted in tangible positive outcomes for the clients they served were strongly rooted in nursing experience, knowledge and training. Broadly, reported outcomes included decreased hospital admissions, more effective medication management, decreased self-harming behaviours, mood stabilisation, improved social integration and return to meaningful occupational activities.

Positive outcomes for clients accessing the MHNIP are noted by other authors (Browne, Hurley & Lakeman 2014; Lakeman & Bradbury 2014; Lakeman, Cashin & Hurley 2014). The Australian College of Mental Health Nurses (2011, p. 4) in a report on the MHNIP, also highlight outcomes such as improvement in symptoms and occupational and social functioning, and less coercive care with more effective use of existing health and community resources.

In a more recent ACMHN survey (2013c) of credentialed mental health nurses working in the MHNIP, similar outcomes are reported. This survey report reinforces the broad extent to which mental health nurses collaborate with and access agencies and primary health care providers for client care and advocacy. Survey participants in that study described ...

... making referrals to other agencies and if necessary providing practical and

emotional support to the person to ensure that they link successfully to the service. They described completing referral documentation, convening meetings, accompanying them to appointments, advocating on the person's behalf and maintaining contact with the organisation over time (pp. 38-49).

The Australian Department of Health and Ageing's (December 2012) evaluation of the MHNIP also listed the top five benefits for patients through their involvement in MHNIP as being:

- increased level of care / continuity of care / follow up;
- patients are able to access care in a much more timely manner;
- improved patient outcomes;
- increasing compliance with treatment plan, including medication compliance; and
- keeping patients out of hospital (pp. 47-48).

In another study, it is also asserted that the interventions employed by mental health nurses, that facilitate a positive outcome, are a product of the cooperation and interaction they have by working in concert with their client (Lees, Procter & Fassett 2014; McAndrew et al. 2014).

The data from participants in this present study reinforces and extends these notions of the influence that relational aspects between the mental health nurse and their clients have on positive outcomes. In terms of determining appropriate outcomes from care planning, a number of aspects emerged from participant data that revealed that the mental health nurse/client interaction is a distinct experience each time, and outcomes, as a result of it, are not always predictable in advance, unlike prescribed interventions which can have a fixed pathway to expected outcomes. Accounts from participants also indicated that objective and quantitative methods of measuring outcomes do not play a key role in driving nurses' interventions or practice. The outcome measures they employed were more informal and client-focused in that they related to the client's aspirations for an outcome. Put another way, aspirational outcomes were co-constructed with the client through the mental health nurse noticing what changes were needed, and negotiating with the client what was possible and desirable in that particular and individual situation.

As an example, one mental health nurse appreciated the function of objective outcome measures in terms of evaluation and accountability. However, this nurse preferred to assess potential outcomes that were related to clients' overall functioning irrespective of a judgement about their performance that standardised and objective measuring instruments may imply.

*"Nursing is real. You measure on real things. How do they live their lives? Do they work? Do they have relationships? Do they sleep? Do they hurt themselves? Do they quite like themselves? Can they manage? That's a measure! There is no judgement" (MHN participant 2).*

Indeed, another mental health nurse participant related that using objective outcomes measures, in the absence of genuine client-focused care, can actually work against desired outcomes. This mental health nurse routinely used a validated client self-scoring indicator to determine readiness for discharge from the service. She considered that an aspiration toward discharge, as an outcome, respected the dignity of the client to manage their health issues independently of the service, and therefore, from her perspective, was a desired outcome respecting the client's goal of independence. She noticed that, for three of her clients, who were repeat users of the service, their self-evaluated score never got to a point that indicated readiness for discharge from the service. This was inconsistent with her observed assessment about their level of functioning. Her response was as follows:

*"One day I thought I would test this out. If I reassure them that they are not going to be discharged in a hurry unless they are agreeable to it, and if I say that I believe minimal support is better than no support, I wonder how that would change the scores? Well, the improvement in their scores was remarkable because they were now reassured that they will get a little bit of support if they need it. But, the discharge has to be agreeable to them and not to the case worker, despite what the indicators are saying" (MHN participant 30).*

The examples above demonstrate a number of attributes associated with a mental health nursing ethos of care; holistic in its perspective, client-focused, relationship-based, collaborative, co-constructive, and flexible. These professional attributes are discussed in more detail in the previous sections addressing the nature and scope of

mental health nursing and its practice. It is argued that the confluence of these factors, coalesced in a culture of caring, determines aspirations for the appropriate outcome, how they are achieved, and is an orientation to care that is productive as a result and distinctive to mental health nursing practice.

#### **5.6.3.2 Collaborating for good outcomes**

Collaborative partnerships in mental health care is a core domain in supporting personal recovery for clients (Australian Health Ministers' Advisory Council 2013b). Mental health nurses implementing care in a primary care setting bring a distinct focus and application of care that affords positive outcomes to the clients they serve. Data from this research study indicate that the nature and scope of mental health nursing is founded on collaborative relationships on a number of levels and places this discipline in a good position to model this practice for improved client outcomes.

The foregoing interpretation of data claims that mental health nurses fill gaps in service provision either in the absence of, or in concert with, other disciplines. It further asserts that mental health nurses provide interventions often at a basic level of care that is not identified as the remit of other disciplines. They engage in a broad range of interventions with clients that provide a holistic approach founded on their background training and experience. In this way, they make a contribution that is distinct in the multi-disciplinary mix of service provision and complimentary to the skills and expertise of other disciplines. It is proposed that these skills and application of expertise are different and special to the clients they serve. The priority of collaborative focus is the client, working with them to determine what is required and what other levels of collaboration with others facilitate the best outcome for them as they, the clients, have determined them.

*"It's about figuring out your network of support and not working in isolation. My network might not be other mental health nurses. It might be other people who have come into my arena, or other referring bodies, GPs, or it might be other health practitioners, anyone that I see now as part of my care team for that particular client" (MHN participant 13).*

Collaboration in a multi-disciplinary context allows tensions and challenges to surface where there are different paradigms, perspectives and perceptions of care. This can work well for positive client outcomes in that different and diverse

interventions are discussed to devise a composite and effective care plan. It is also crucial that the client is in this mix, as one of the barriers to effective care can be the claim of a single expertise in care delivery. The data have revealed that the mental health nurse is often the broker between the professional view and the lived experience view. They discern where the skills and motivations for an outcome are, and negotiate the best contributors for the particular outcomes that are generated in concert with and agreed to by the client.

### **5.6.3.3 Working with clients from ‘where they’re at’ to resolve issues**

Participant data, previously alluded to, indicates that responding to client needs, in the moment of contact with them, is important and instrumental in formulating appropriate interventions. This does not preclude, however, interventions that involve predictable and conventional or prescribed treatments, such as medication management. It does involve, though, mental health nurses making concessions for the client at the time of contact, such as where they meet and what interventions have priority. So judging where the person is at, and this means being with the person in the moment, will determine what, how, when and where an intervention is executed. Participants described this phenomenon of ‘being with’ the client. They are prepared to get close to what the client is facing in terms of challenges and are prepared to experience this along with them. This guides their understanding, sensitivity and assessment in terms of possible resolution or adaptations to the challenges at hand. Mental health nurses are used to this contact as they consistently experience caring at a close and hands-on level over sustained periods with individual clients. It is what mental health nurses do. They become familiar with endurance, persistence and tenacity and see the value of persevering with clients. They work with and through uncertainty, taking whatever time and collaboration is required to affect an outcome.

*“Nurses are with their patients at various times of night and day, and in different environments, whether home visiting or out in the community or in an inpatient setting. So we see patients in different levels of function and roles and in different seasons. We meet carers and family members and liaise with them. We can assess home environments for those doing home visits. We see a lot of sides to patients that others don't see” (MHN participant 20).*

This distinct mode of practice confronts mental health nurses with a range of issues needing to be addressed. They will do whatever it takes to resolve an issue; shopping, socialising, exercising, and in the process, verbal and social interaction occurs. It is speculated that this has a normalising impact for the client. With the mental health nurse walking beside them and sharing the experience with them, this makes the experience 'normal' and can help reduce stigma. Decisions about a venue for an intervention can often be chosen for its therapeutic value in this context. For example, meeting in a coffee shop has social and interactive goals. However the setting can place limitations on what other interventions may be explored, such as facilitating emotional expression of negative emotions where a more private setting may be appropriate and choices are made about what are the priorities for intervention at the time.

Through these practices, mental health nurses mould their interventions to provide a fit with their clients' preferences along with their own preferences for interventions they may see as relevant. When asked how this mental health nurse determined what was dealt with in their interaction with a client, the response was:

*"I would normally, in the first session, ask the person what their goals are, what are they hoping to achieve from the sessions and we set some goals together. And they are normally practical things. So they might say "I want to reduce my anxiety" so we'll explore how we might do that or specifically what they might be wanting to target and try, and make it small to start with. Sometimes they might have practical things. When I first started in this job, someone came to me with a housing issue. I was sort of loathe to work on it because I thought housing was not really part of my role. It's not my favourite part of the role, but now I just say, OK, well housing is where we are, so that's where we will start" (MHN participant 20).*

Another mental health nurse described the interactive partnership with her clients in this way:

*"I might have an idea of what might be useful. I can hold on to that in the background and sit with someone while they find out how to tackle a task. It might not have been the way I would have gone about it, but generally it will be better because it is what is right for them" (MHN participant 32).*



The conclusion from these accounts is that there is a fluid dynamic in the nurse-client therapeutic alliance. It is characterised by negotiation and compromise. The pathway to an outcome is not fixed. Interventions and their priority are based on individual needs, presentation at the time, and/or how positively clients respond to proposed or implemented interventions. The interaction between the mental health nurse and the client builds a momentum and growth in each, which in itself, is a positive outcome of this interchange. It is expressed in this account:

*“There's an expansion that occurs in the relationship between the mental health nurse and client and within each person, with the client's abilities and resources expanding as well as the mental health nurse's. This is a fulfilling and life giving outcome”* (MHN participant 20).

Sensitivity to the client's current state of readiness for change and working in partnership with a client flexibly to determine appropriate interventions, creates the landscape for effective outcomes.

#### **5.6.3.4 Using varied evidence to guide interventions to achieve outcomes**

Mental health nurses, along with other health disciplines, adhere to a commitment of engaging evidence-based practice. The question of what constitutes 'evidence' is pertinent to this study.

McCormack, Manley and Garbett (2004), in exploring the interpretation of research into practice in a nursing context, identify three strands of evidence. They name these as 'research evidence' from empirically based studies, 'evidence from clinical experience', and 'evidence from those who use healthcare services'. The application and implementation of these sources of evidence as single entities or as interactional in and between each approach, is tempered and influenced by the context in which they are applied. The culture of the organisation, its leadership and evaluation priorities are all determining factors (pp. 121-135).

Pearson and Craig (2002, pp. 8-10), examining evidence-based medicine, assert that empirically-based research that narrows concepts to 'investigations and treatments' is not broad enough to capture nursing practice. They purport that nurses do not simply treat particular conditions; they care for the person with the condition, and therefore need to draw on a wider range of research-based evidence.

As expounded in Chapter 2 of this thesis, the notion of the confluence art and science as a distinguishing feature of nursing has been extensively discussed in the literature. There are some specific references to mental health nursing that propose that the 'art' deals with less tangible health challenges and phenomena that require humanistic and intuitive interventions as a priority along with 'scientific' explanations. The scientific evidence base is often accentuated as preferred and essential for responsible and accountable practice. It is proposed that, for mental health nursing practice, the evidence base for the 'art', so called, comes from knowledge and phenomena experienced in practice, the most significant part of which is with and within the nurse-client relationship. It is therefore argued that evidence from this experience, which includes the evidence expressed by the client's lived experience, also needs to be acknowledged and accepted as veracious.

A significant driver for mental health nursing interventions, gleaned from participants in this study, is to follow the client's lead, engaging a recovery paradigm. This relies on taking evidence about appropriate interventions from the client's own experience and acknowledging their aspirations as an equal priority to any other source of evidence for action. As interpreted from data in this study, it is purported that mental health nurses respond to this context of care. They collect and experiment with therapies and interventions. They selectively pick those that suit the situation and seem right for the client and themselves. While these interventions may demand adherence to certain 'evidenced-based' criteria for their efficacy, nurses may vary and adapt these to fit with the individualised care they offer. This is executed with an ethos of providing safe practice and ensuring that whatever interventions are employed, they first and foremost convey that the client is valued as a person and that their input is heard. The following quotes illustrate the need for various sources of evidence to determine appropriate interventions, which include the suggestions and guidance of the client as a contributing expert about desirable care:

*"I think nursing is distinct, it's separate. We can be like magpies. We draw from other theoretical approaches that can help understand therapeutically what we do. I think we're more therapeutic than we actually give ourselves credit for. We should be more guided by that, glean from other approaches, not just from psychology or psychiatry but from other therapeutic approaches that could be helpful to our practice and that would make it more meaningful*

*for people. Randomised controlled trials; nursing holds it as the standard. But where is the individual patient in that? He doesn't exist. What we do is evidence-based practice, but that evidence is also presenting clinical material and what the patient says"* (MHN participant 11).

*"It's very much our regard for them as a human being and they choose the pathway, they choose the way they want to go. We walk alongside them. But at the same time we are sensible enough to say – "I'd give some thought to that outcome, it might not work for you". So we would give them advice, direction and guidance. But it is all done hand-in-hand"* (MHN participant 23).

The prompt for what intervention is employed to achieve acceptable outcomes is understanding 'what's in the room', taking cues from the client as a priority rather than a standard prescription of intervention based on criteria such as diagnoses. The philosophy behind this is that, in prescriptive modalities such as clinical pathways based on medical diagnoses, there is no 'individual'. Standardised interventions are about identifying common denominators across the experience of a number of case studies. In psychiatry, diagnoses are based on peer-reviewed clinical opinion rather than hard empirical evidence (Szasz 2008; Timimi 2013). Such 'evidence' may be acceptable as a guide but not always indicated for individualised care.

McKenna (2009), while acknowledging that the term 'evidence-based practice' is common parlance in the healthcare domain, prefers the term 'evidence-informed practice'. While there are many definitions of this concept, he favours a definition attributed to McKibbin et al as the most comprehensive. McKenna (2009, pp. 30-31) describes this as 'an approach to health care that promotes the collection, interpretation and integration of valid, important and applicable patient-reported, clinician-observed and research-derived evidence'.

This is a more inclusive definition of evidence-based practice. The evidence determining the course for the best outcome is that which is negotiated at the time, based on the client's perception of what is important to them in terms of change, and what sources of knowledge and skills for intervention the nurse has at their disposal.

*"New evidence for improving mental health and well-being is coming all the time. We use this evidence and this informs our practice. For example, the benefit of exercise with depression and anxiety. However, as mental health*

*nurses, we use the evidence base, but we also meander where we need to go in response to what the client needs at the time rather than just sticking to a pre-determined, structured approach dictated by particular evidence-based interventions” (MHN participant 32).*

Interventions by mental health nurses, based on what is seen in the present relationship with the client, can therefore be unpredictable in terms of outcome. The premise of whatever works for that individual is guided by a sense of responsibility for every aspect of the person's life and respect for their experience of knowing what will work for them.

#### **5.6.3.5 Nursing clients on the recovery pathway**

Based on the data in this study, it is proposed that nurses are well placed to support recovery principles. Their practice is attuned to the needs and wants of the client. They are comfortable with the client asserting their expertise and are prepared to go with whatever course the client chooses as long it is within their statutory capacity to do so, is negotiated as potentially beneficial, and is safe thereby complying with ethical principles.

Mental health nurse participants in this study claimed that their interaction with clients involved being able to have a broad view of the client and their needs, and a broad vision to assist them in their recovery. This was supported by a commitment to, and skills in, staying with a client no matter how challenging, to guide and co-ordinate care and interventions, and monitor progress until they saw that the client no longer needed that level of intervention by them. They provided continuity as they orchestrated the fit between the client's positive health goals and provision of whatever support was available to meet their goals towards independence. These accounts and interpretations from the data in this study are also echoed in the work of others.

In a review of the British literature, Bonney and Stickley (2008) posit that putting the philosophy of recovery into practice, which has self-responsibility at its heart, offers some challenges. They maintain that ‘self-management’ should not be the prescription of professionals but be achieved by genuinely empowering individuals, which includes real choices by clients and engendering hope in the belief that problems are soluble rather than permanent. This is divergent from an ‘illness’

approach to care where professional expertise takes prominence. In contrast, they propose a 'recovery' approach emphasises 'recipients of care ... being experts because of their experience' and they support flexible health care systems that are prepared to take risks to support a recovery approach where the agenda is about 'potential and expectation' rather than 'safety' alone (p. 149). They address the implications of a recovery approach for mental health nursing, which they argue will require nurses to ...

... allow service users to define recovery for themselves and to work collaboratively with the service user's own style. The acknowledgement of the factors that hinder the individual's journey to recovery has implications for the nurse to promote autonomy over and above a protectionist and defensive practice modus operandi. Perhaps nurses' thinking about recovery requires a deconstruction of past and current thinking around mental illness and the role of the nurse and work towards becoming a navigator or facilitator along the way of another's journey as lives become reconstructed (p. 150).

Therefore, contemporary principles of recovery need to be understood by mental health nurses and incorporated into their practice. Cleary et al (2013) report an association of holistic, person-centred and humanistic practice with recovery approaches in their study exploring mental health nurses' views of recovery in acute in-patient facilities. However, the context of acute in-patient units inhibited the application of such models because of the practical realities of short lengths of stay and restricted time with the intrusion of ward tasks. Their findings indicated that 'there is need to challenge and clarify some of the personal values of acute care nurses and to take a collaborative consumer-focused orientation' and more staff education was needed to affect culture change in that environment (pp. 209-210). Targeted education for recovery-oriented practice is supported in other studies (Gale & Marshall-Lucette 2012; Knutson, Newberry & Schaper 2013; McKenna, B et al. 2014; McLoughlin et al. 2013).

Caldwell et al (2010) examine the shifting paradigm in mental health care towards a recovery approach and in particular, focus on the nexus between mental health nursing and the recovery process which they see as a 'natural fit'. Their rationale for this claim is the distinctive holistic orientation of nursing that has 'focused on

approaching clients as individuals within a wellness-oriented and collaborative care delivery model'. The nurse-client relationship inherent in this process should, they say, 'continue to define the core identity of psychiatric-mental health nurses' who should also take a strong leadership role in modelling and advancing this paradigm of care (pp. 42-44).

The association of a recovery approach and holism in mental health nursing is also addressed by Byrne et al (2013). In their qualitative exploratory study of undergraduate students who were taught by an academic with lived experience of mental health issues, respondents reported that the recovery principles to which they were exposed increased their 'appreciation for holistic nursing and an increased capacity for reflective understanding' impacting their attitudes and consequently the quality of their practice (p. 265).

The mental health nurse participants interviewed in this study well understood and indeed applied recovery principles in their practice. They also associated the commitment to this approach as one well suited to and rooted in their learned practice as a mental health nurse. One participant's reflection on the role of the nurse in this relationship is expressed as follows:

*"Mental health nurses sowing the seeds of hope where there is a perception of hopelessness, nurturing them to their potential. That is the art for recovery facilitation for the emotionally troubled"* (MHN participant 33).

#### **5.6.3.6 Asserting nursing identity, credibility and status through positive achievements**

Mental health nurses interviewed in this study attached meaning to their work based on the positive outcomes they have achieved for their clients through their distinct contribution as a nurse. Over 20 years ago, Barker (1989) wrote:

As nursing moves towards the 1990s it is eager to define itself more clearly. This is, in part, a conscious striving after 'professionalism'; but may also contain an element of 'survivalism'. Nurses need to secure their identity in order to reassure themselves, and others, of their worth. This involves a search for a meaning in their work which, at the end of the day, will be no more than the meaning they attach to it (p. 139).

The perception from some mental health nurse participants in this study was that it was demoralising when their role was interpreted, and at times directed, by others who fail to understand the nature and essence of nursing in terms of its capabilities and distinct contribution. It was also expressed that some aspects of the culture of nursing itself scorns nurses for going outside of nursing, for example to practice as a psychotherapist which was perceived as not 'nursing' by some. However, participants reported that working as an independent practitioner enhanced their identity by demonstrating and fulfilling the expectations of professional mental health nursing standards in their practice.

*"Working as a private practitioner, I love every day. I never know what I might be doing exactly, I have great freedom in my work and I am valued and respected, and that allows me to work in in an incredibly different way. When you are treated so well in your work it assists in helping others go through what they're experiencing. You have much wider scope in your practice, it's exciting and nice work"* (MHN participant 32).

The following extract from an interview expresses the benefits of working through identity issues in order to adopt a self-responsible and productive professional image.

*"If you're proud of nursing, you can get something more out of it. I was angry with nursing because I felt let down by it. It should have grown; it should have triumphed. When I turned around and stopped being angry with nursing, I could find little gems in there. I know when I started to be confident in myself as a professional; it was when I could say that I was independent and could practice independently"* (MHN participant 11).

The MHNIP has allowed mental health nurses, working in private practice and in primary care, to identify their practice as nursing rather than assuming generic titles such as counsellor or psychotherapist. For the mental health nurse participants interviewed, this reinforced an identity with a professional status that is valued by them. For mental health nurses working in this autonomous way, the positive outcomes they achieved for clients establish their credibility both in the eyes of the clients they see, and in the eyes of their health colleagues who rely on them to complement their care. The MHNIP has provided an opportunity to promote the

distinct contribution made by mental health nurses and this opportunity can be exploited to better understand and define their practice.

#### **5.6.3.7 A hypothetical construct of what is special about the consequences of mental health nursing**

Mental health nursing is not only defined by how it was or has been, but by how it is applied across time in a changing environment and what has endured in terms of an orientation of learning, ethos, practice, and application of knowledge. It brings a particular professional construct to its caring role and as a result, executes this role in a special way. The consequences of this nursing orientation to care are positive and productive.

The outcomes that mental health nurses pursue from the beginning of their interaction with a client are not certain. Clarity and certainty grow as a result of the interaction, taking the time to be with and listen to the client's explanation of their challenges and how they are equipped to deal with them. This process involves building a trusting relationship and interpreting nuances within it in order to determine what the client wants to achieve in terms of outcomes, and what capacity both the mental health nurse and the client has to meet those needs. If this requires additional expertise and support, the mental health nurse will pursue these in a coordinated and determined manner. So the process of determining outcomes is based on the interactive experience with the client, taking their cues to guide action.

The mental health nurse is not alone in this work. They rely on the experience and expertise of the client and other health care disciplines to affect an outcome. They do, however, readily take on the responsibility of coordinating this care being mindful of their ethical duty to ensure that any and every intervention is for the benefit of the client. This responsibility is clear to nurses whose culture of caring is based on seeing a broad picture of the client's life and needs within it, and understanding how, when and where different expertise and resources can contribute to an effective result that the client generates and aspires to.

The sensitivity required to obtain this insight is gained through working alongside clients in a close and intimate way that is intrinsic to mental health nursing practice. Outcomes are not prescribed though the application of professional expertise as the dominant influence, but along with and through a co-constructed and individualised



interactive process with the client that acknowledges their rights, choices, wisdom and expertise in determining the best outcome for themselves.

The consequences of mental health nursing practice, as interpreted and described, have impact beyond the primary goal of positive client outcomes. The execution of mental health nursing practice that yields effective results also reinforces the distinctive role, expertise, skill and knowledge that a nursing paradigm brings to mental health care. It is specialist in nature, broad in its scope and potent in its influence and provides clarity about the purpose, aim, identity and impact of this special contribution.

The hypothesis of what is special about the consequences of mental health nursing is summarised in Progress Bulletin No 14 (Appendix 24). It reinforces that positive outcomes are achieved through processes of collaboration and partnership. It makes reference to the concepts of co-construction and contracting to underpin consequences that result in mutual benefits for both mental health nurses and those they serve.

#### **5.6.4 Defining a core category**

Birks and Mills (2011, p. 173) define a core category as a 'concept that encapsulates a phenomenon apparent in the categories and sub-categories constructed and the relationships between them'.

The conceptual framework in Figure 13 outlines and describes the interrelationship of three major categories identified. It is drawn from data from interviews in the context of what is special about the nature, scope and consequences of mental health nursing and provides an explanatory statement linking and interrelating these aspects. It diagrammatically portrays how the major conceptual categories reflect the nature, scope and consequences of mental health nursing. The properties of each of the major categories are explicated in the preceding sections. The interrelationship between the major categories and their properties is represented in Table 6.

**Table 6:** Interrelationship between major categories and their properties

NATURE	SCOPE	CONSEQUENCES
<b>Using the distinct nature of mental health nursing in the service of others</b>	<b>Working to the edge of practice boundaries with the client</b>	<b>Pulling together collaboratively developed interventions for positive outcomes</b>
Becoming and being a mental health nurse	Defining and distinguishing distinctive practice	Asserting nursing identity, credibility and status through positive achievements
Constructing meaning to everyday tasks Doing what no-one else will do	Making time and being flexible	Working with clients from 'where they're at' to resolve issues
Being there	Context of care potentiating mental health nursing scope of practice	Using varied evidence to guide interventions to achieve positive outcomes
Interacting therapeutically as a mental health nurse	Relationship based and client-focused nursing care	Nursing clients on the recovery pathway
Seeing holistically	Working holistically	Collaborating for good outcomes
Acknowledging and respecting client perspectives	Collaborating in care	Determining appropriate outcomes through partnering

This alignment of properties of each major category encapsulates the essence of the phenomena of interest in this study. The hypothetical constructs of each category are interpretations of participants' accounts of what they considered special about mental health nursing. It acknowledges that mental health nurses are part of a collaboration of care delivery that includes the client and other care givers. Each of these contributors bring their construct of the world to the caring relationship with aspirations and potential for improving health. These include an ethos of humanity in their encounters, specific knowledge and experience, motivation towards healing, and influence to affect change.

It is proposed that these phenomena are expressed and experienced differently by health professionals and the clients they serve. For example, for the health professional, care is based on humanitarian giving that is altruistic in intent, that is, motivated by the welfare of others. For the client who is the recipient of health care, their concerns are egocentric, or focused on their individual recovery. Professional

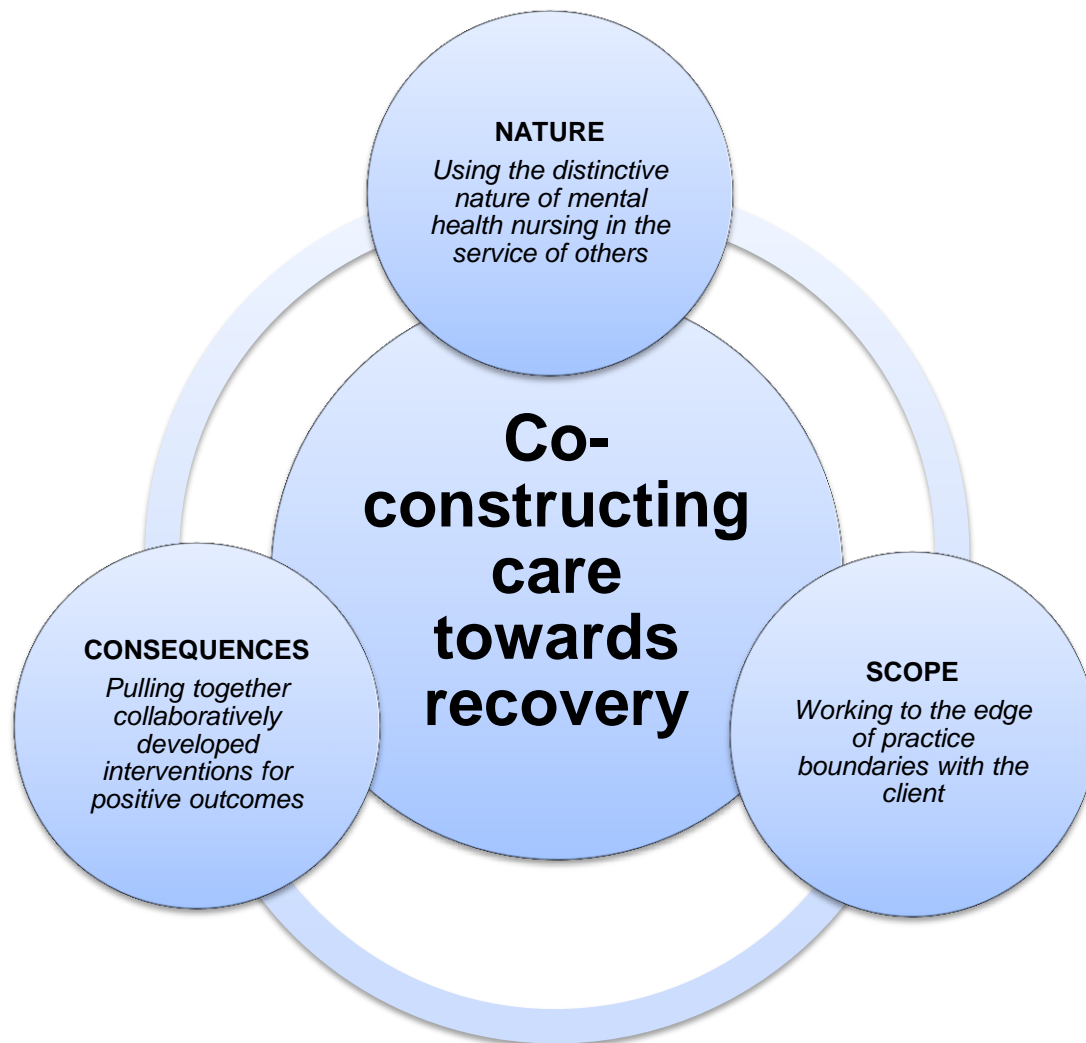
knowledge is derived from scientific evidence and experience across many clinical encounters and is general in nature as a result. Therefore, aspirations for health improvement is by providing expertise in identifying causes of diminished health and using professionally acquired knowledge to deliver interventions that ameliorate the health aberrations identified. Their influence in changing health status is expert power executed through prescribing interventions that are within the knowledge, skill set and experience of their particular profession or discipline. The client's knowledge, however, is rooted in lived experience, is specific, and aspirations for health improvement are sought using whatever expertise or interventions are available to affect outcomes that they desire, which at times may not accord with the aspirations of health professionals. Personal change is influenced by what makes sense to them at the time, their readiness to pursue suggested interventions about which they may be uncertain in terms of outcomes, and a desire to have ultimate control in the implementation of change strategies.

It is asserted in this thesis that mental health nursing provides a contribution based on its foundational professional knowledge, experience and ethos which is expressed in practice that is different and complementary to other care givers and distinct for its relational aspects with the clients it serves. An argument is built in the preceding sections that this contribution mediates anomalies in professional and client expectations of care through mental health nurses' close alignment with their clients which exposes these tensions in order to address them in concert. This is expressed as co-constructed care.

Conceptualised to a higher level, these aspects of the major categories coalesce into a core category which is explained in the following section.

#### **5.6.4.1 Co-constructing care towards recovery**

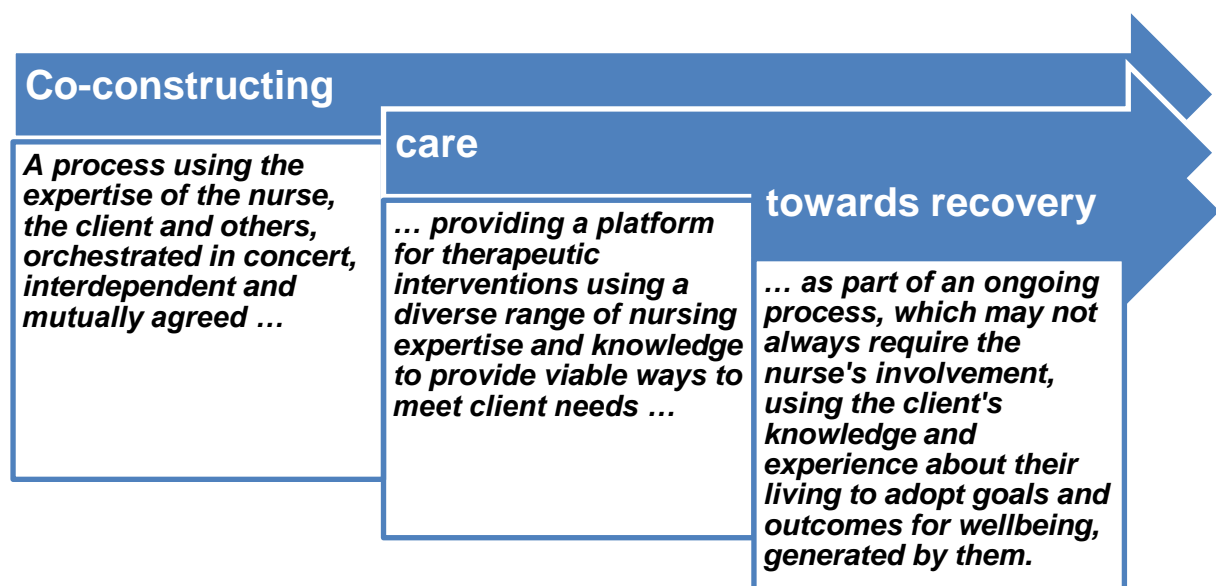
Encompassing and linking the three major categories, a core category is identified and titled '*Co-constructing care towards recovery*'. The relationship of these categories to each other is illustrated in Figure 17.



**Figure 17:** The core category of 'Co-constructing care towards recovery' and its interrelationship with the three major categories identified

The above process illustrates that the distinct nature and identity of mental health nursing drives and influences its practice in a peculiar way. This practice is based on an interaction with clients that is inclusive and collaborative, broad and flexible. The result is special, productive and positive outcomes that satisfy the therapeutic aspirations of both the clients and the mental health nurse, encompassing a notion of recovery as determined by the clients they serve. That is, the nature of the discipline of mental health nursing itself, its work and the relationship formed by nurses with clients, is an interdependent and interactive interplay that is special and productive. The process involved is one of co-construction with its aim to provide viable care based on the composite knowledge and experience from those participating in the process. The goal of this process is to achieve the optimum level of wellbeing for the client that is maintained with as much independence by the client as possible. An

overarching explanatory statement of this concept as the core category interlinking the major categories is expressed in Figure 18.



**Figure 18:** Explanatory components of the core category

The core category as depicted in Figure 17 and its explanatory components outlined in Figure 18 were incorporated into Progress Bulletin No 15 (Appendix 25). This conceptual construct proposes that a mental health nursing perspective of care is an acquired lens facilitated by the nexus of the nature of mental health nursing and how it is experienced in practice, which uses a recovery approach to affect positive outcomes.

Within that practice, the relational interplay between the nurse and the client is distinct for its co-constructed property. Practice that is co-constructed with the client sensitises mental health nurses to being open to influences other than those professionally prescribed. It facilitates the mental health nurse to adopt practices that marry the artful, based on intuition, metaphysical knowledge and experience using client reported and nurse-observed evidence, with the scientific, based on professionally sourced knowledge using research-derived evidence. The result is a therapeutic and beneficial coupling that blends these practices, and is demonstrated by a melded practice that is concurrently, humanistic and professional, co-constructed and contractual, collaborative and purposeful, and empowering and power-sharing. This phenomenon is generated by this distinct way of relating and

interrelating with clients and distinguishes mental health nurses in their practice. The elements of this blended practice are represented in Table 7.

**Table 7:** Blending artful practice with scientifically based practice

<b>ARTFUL practice blended</b>	<b>with SCIENTIFICALLY based practice</b>
<p><b>HUMANISTIC</b></p> <p><i>Artful practice involves interpreting nuances within the therapeutic relationship using intuition and client-reported evidence as a guide ...</i></p> <p><i>Uses humanistic responses ...</i></p>	<p><b>PROFESSIONAL</b></p> <p><i>... in concert with scientific practice using nurse-observed and research-derived knowledge to guide and inform a range of possible interventions.</i></p> <p><i>... and professionally based ethics.</i></p>
<p><b>CO-CONSTRUCTED</b></p> <p><i>Care is co-constructed with the client ...</i></p>	<p><b>CONTRACTUAL</b></p> <p><i>... in a therapeutic relationship that is negotiated and mutually agreed or contracted.</i></p>
<p><b>COLLABORATIVE</b></p> <p><i>Collaboration with the client and others is effected in order to meet specific and diverse needs as expressed by the client ...</i></p>	<p><b>PURPOSEFUL</b></p> <p><i>... with a therapeutic intent that is purposeful and targeted to desired outcomes generated with the client.</i></p>
<p><b>EMPOWERING</b></p> <p><i>Empowerment towards recovery, as defined by the client, and independence for the client is the aim ...</i></p>	<p><b>POWER-SHARING</b></p> <p><i>... facilitated by an ethos that acknowledges the power differential between the mental health nurse, as a professional person, and the client, deliberately building this relationship to respect and include the expertise of the client, recognising that power is often assumed through acquired expertise.</i></p>

Co-constructing care towards recovery, as a concept that distinguishes mental health nursing practice, requires the mental health nurse to execute their particular skills in a way that acknowledges the partnership with the client as a crucial element in the construction of that care. This awareness and practice encourages and drives the formulation of positive outcomes that are acceptable to the client. Derived from the foregoing conceptual development, it is proposed that mental health nursing behaviours employed to achieve this involve:

1. Developing distinct professional nursing skills and identity. Mental health nurses, as health professionals, aspire to an identity that satisfies their core

values and goals based on their professional nursing ethos and specialist knowledge of both nursing and mental health;

2. Sustained close caring contact and involvement in the client's everyday activities and challenges. This is a professionally intimate relationship with therapeutic intent as its driver;
3. Developing power-neutral or power-sensitive relationships with clients that have them (the clients) as the focus of the care delivered;
4. Adjusting to system constraints and opportunities to maximise the nursing contribution to effective mental health care for those they serve.

The core category developed is the focal point that includes and interrelates the three major categories and their properties. Further refinement of these concepts consolidates an explanation of the interactive, or psycho-social process in relation to the core and major categories that reflect the phenomena of interest in this study. The following section addresses this.

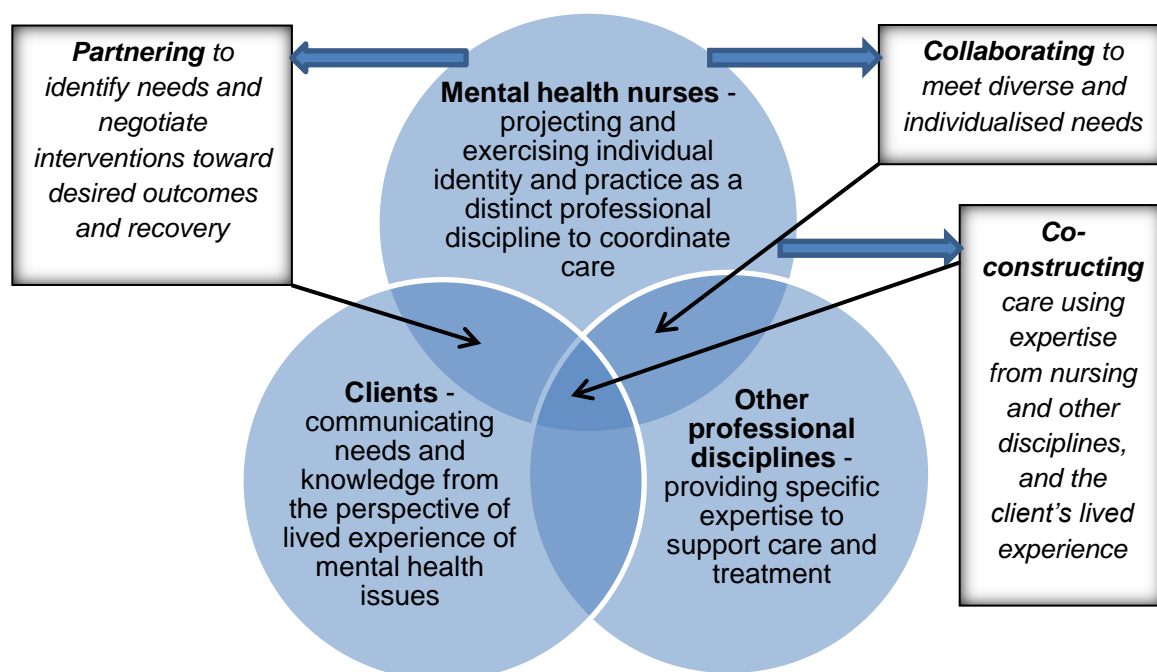
## **5.7 Defining the psycho-social process in this study**

This study's purpose is the development of a theoretical model of mental health nursing practice that helps define its distinctive contribution to mental health care and service delivery. The phenomena of interest are about the nature, scope and consequences of mental health nursing. The study has explored what mental health nurses do, how and what interventions they engage in their practice, and the positive client outcomes that result from this practice. At a conceptual level, it has analysed data from participants to elucidate what is distinctive or special about their practice, providing an explanation of the processes of its care that is distinguished for its special contribution.

The categories described provide an explanation of the phenomena of interest. They address the influence that the identity of nursing has on the genesis of a world view of mental health care that is rooted in the notion of service to others. This perspective, along with intimate, sensitive and responsive caring, brings with it a peculiar sensitivity to the holistic needs of their clients fostered by a relationship with them that is grounded at their level. This is translated into practice which, unsurprisingly, places importance on the relationship with the client as the catalyst

for therapeutic caring. Because it acknowledges and responds to the idiosyncrasies of each client and each encounter of care, it is collaborative, flexible, fluid, enduring and persistent. In sync with the qualities associated with a nursing ethos, it adapts its knowledge and skills in the service of others as the priority. The consequences of this care are positive client outcomes that place the client as an equal partner in negotiation, generation and execution of therapeutic interventions that affect the outcomes they want.

The consolidating theme across this process is that care is delivered and adapted through a process of co-construction between the mental health nurse and their client, using whatever other resources, directly or indirectly, to achieve the agreed outcomes. Throughout this process, mental health nurses use their special professional skills to deliver and coordinate care that is both complementary to other contributors and, at the same time, distinct in its own contribution. The points of intersection among these contributors are where partnership and collaboration are executed, and where co-construction of care occurs. This process is outlined in Figure 19 and detailed in Progress Bulletin No 16 (Appendix 26).



**Figure 19:** The psycho-social process of co-constructing care towards recovery



Mental health nurses are depicted in this process sharing responsibility and influence as one of three contributors. They are not alone in their practice and indeed rely on the contribution of others. The point of intersection between all three contributors depicts the core process of co-constructing care. This is facilitated by the mental health nurse engaging in a special partnering, recovery-focused relationship with the client aided by a collaborative relationship with other professional disciplines. In addition, the mental health nurse takes responsibility for the coordination of this care, the skill for which emanates from their distinct practice.

A diagram depicting recovery-focused care may have the client at the centre. However, the purpose of this study is to depict a model of mental health nursing practice that facilitates positive outcomes for clients and to highlight the distinct contribution of mental health nursing in that process. Therefore, it is not about recovery alone, but the interaction and interdependence that is in play in that process.

The psycho-social process outlined, supported by and interactive with the core category which in turn is supported and interactive with the major categories and their properties, serves to provide the foundation towards a consolidated theory of mental health nursing practice through further and advanced conceptual development. The theory constructed that reflects this is discussed in Chapter 6.

## **5.8 Progress Bulletins 9-16**

Progress Bulletins 9-16, summarising the major categories, core category, and psycho-social process were disseminated to mental health nurse participants for comment and feedback. These participants were asked to consider the concepts that were constructed in the context of their experience of mental health nursing that they had expressed in this study. Initially, two Bulletins (7 and 8, Appendix 20 and Figure 13 respectively) were sent to participants as a group email bringing them up to date with progress in the 12 months since the last Bulletin (number 6) was sent. This did not yield many responses. Therefore, it was decided to send the next eight Bulletins (9-16) to the 36 mental health nurse participants individually one week later. These Bulletins covered the major categories, core category and psycho-social process developed from the data they had contributed. In addition, the email accompanying

the Bulletins solicited a request for general feedback and also gave a summary of the Bulletins, through four specific statements related to each set of Bulletins, covering their content which could be answered as briefly or comprehensively as they wished. Participants were also offered the option of a brief telephone discussion rather than, or in addition to, a written response if they preferred.

Specifically, the following statements, contained in the email, asked participants to consider whether the concepts outlined in the Bulletins resonated with them:

1. The nature of nursing is influenced by its 'service to others' and its 'on the ground' interaction with clients. In mental health, this facilitates a client-centred focus that is intimately in tune with their life needs as well as health needs (Bulletins 9 and 10, Figure 14 and Appendix 22 respectively);
2. Mental health nursing practice is determined by the nature of the nursing world view and delivers broad, flexible, time intensive care that goes beyond health and professional paradigms to individual commitment to client generated care (Bulletins 11 and 12, Figure 15 and Appendix 23 respectively);
3. Outcomes of mental health nursing care are facilitated by acknowledging and responding to client needs that are generated by a special collaboration with clients and others and result in mutual benefits (Bulletins 13 and 14, Figure 16 and Appendix 24 respectively);
4. The distinctive contribution by mental health nursing is characterised by care that is collaborative, co-constructed with the client and as a consequence, committed to a recovery approach that results from the special way in which nurses view, relate and respond to individual client needs (Bulletins 15 and 16, Appendices 25 and 26 respectively).

This strategy yielded a better response. To boost this, one final Bulletin was sent to individual participants again two weeks later. This Bulletin (Bulletin No 17 – attached as Appendix 27) gave an overview of the exploration of the initial question, 'what's special about mental health nursing', and the tentative theory about mental health nursing that this question generated.

Overall, these strategies resulted in responses from a total of 13 participants, or 36% of the mental health nurse participants. Seven participants provided a written

response with six opting for a telephone discussion which, for each, was audio recorded. The same Bulletins were sent to other colleagues, national and international, who had expressed an interest in receiving them, by group email. While they were invited to comment, their responses were not treated as data as they were not formal participants in this study. These emails yielded comments from 3 persons.

The feedback from participants was used to cross check that the interpretations made of their data from interviews represented the sentiments they expressed and were faithful to their understanding of mental health nursing as a discipline as they practiced it. Feedback from all participants who replied provided strong affirmation of the concepts developed as they were portrayed in the Progress Bulletins, which in some instances were further clarified through telephone discussions, where applicable, and email correspondence.

Apart from this process quality check, the information obtained was also used to refine and progress conceptual development from the data to more sophisticated levels, consistent with theoretical sampling in grounded theory. This facilitated re-appraisal of the categories and their properties to ensure that all relevant aspects of the data had been attended to. Some quotes from participants confirm the usefulness of the Progress Bulletins:

*“This is a very impressive piece of work, having someone articulate my practice which requires some specificity and expansion. It reminds me so much of what is so valued in our work: “You gave me your ears and used language that validated my experience” -this is what clients have said. I believe your research has done the same. It has validated something which has been a bit nebulous and not that well defined. It resonated with me considerably. Thank you, your research has described and defined something for me” (MHN participant 13).*

*“I’ve really looked forward to your Bulletins to see how you’re progressing. I’ve found them very useful as they validate who I am. It’s like reading about myself. It read like you’ve written an article about me and I’m sure that whoever else is involved in your research probably thinks the same. On a*

*personal level, this is what we do. And to have it put in such a sensitive way is really validating” (MHN participant 30).*

Having satisfied this requirement for quality and rigour in the research process and having consolidated the additional data from participants, the foundation was laid for further conceptual analysis to generate and integrate a theory of mental health nursing in the context of this study.

# Chapter 6

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## *A theory of mental health nursing*

### **6.1 Advanced coding: Constructing theory of what's special about mental health nursing**

In generating a grounded theory, data are interpreted and similar issues and themes are given conceptual labels or codes. These are refined and reduced to major categories containing properties that define the concepts of each major category. From this, a core category is generated and interrelates with the major categories. Together, they reflect the essence of interpreted data and the relationships between the concepts within them and represented as a psychosocial process addressing the interactive process inherent in the phenomena examined.

For the integration of a grounded theory, analysis occurs at the highest conceptual level. This level of analysis requires accumulated analytical memos, theoretical saturation of the major categories and an identified core category.

In the case of this study, data were sourced from participant interviews and from the literature. The generation of concepts are articulated in the three major categories and consolidated in an explanation of the core category and psycho-social process related to the phenomena of interest as outlined in the previous chapter.

The final step of theory generation, as outlined in the schema for grounded theory used in this study (Figure 4), proposes that the process of integrating theoretical concepts is facilitated by theoretical coding. Theoretical codes are integrative, says Charmaz (2006), as they ...

... lend form to the focused codes collected ...help you to tell an analytic story that has coherence ... and ... not only conceptualize how your substantive codes are related, but also move your analytic story in a theoretical direction (p. 63).

This study started with the question 'What's special about mental health nursing?' In a grounded theory context, this question represented a general wonderment about

phenomena related to the interaction of mental health nurses with their clients. It explored the nature and scope of this relationship in terms of its positive consequences and distinct contribution to care.

Throughout this process of inquiry, adherence to this initial question as a driver for the exploration of these phenomena served to preserve a 'general wonderment' until concepts, emerging from the data, consolidated into discernable categories and an explanation of a psycho-social process reflecting the phenomena explored. This is evidenced by the title of the study, framed around this question, being used up until the dissemination of the final Progress Bulletins, after which the title could be re-framed to reflect the transformation of the consolidated concepts into an integrated theory of mental health nursing that reflected the interpreted data.

Characteristic of the majority of grounded theories, the resultant theory in this study is a substantive one, or middle-range theory<sup>25</sup>, as it addresses issues in a specific substantive area. In contrast, formal theories address issues across and between several substantive areas at a higher conceptual and abstract level. Both types of theories, though, need to be grounded in the data to have value (Birks & Mills 2011; Charmaz 2006; Glaser & Strauss 1967). In the case of this study, the substantive area addressed is mental health nursing practice and its influence on client outcomes in an Australian context.

## **6.2 Being in the here and now, side by side, co-constructing care: A substantive grounded theory of recovery-focused mental health nursing**

The theoretical construct that is a consequence of the grounded theory research process outlined is reflected in the re-formed title: *Being in the here and now, side by side, co-constructing care: A substantive grounded theory of recovery-focused mental health nursing*.

This title brings together an explanation of a process that reflects the distinct contribution of mental health nursing to service delivery and care. In order to

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<sup>25</sup> In contrast to grand theories that are systematic constructions of the nature of nursing, middle-range theories are more limited in scope, have less abstraction, address specific phenomena or concepts and reflect practice (Meleis 2012, p. 33).

explicate this, its component parts require explanation in the context of its preceding categories and their properties, the core category and the psycho-social process generated. The resultant substantive theory of mental health nursing is the product of interpretations grounded in data from participants and augmented by data from the literature.

Singularly, each significant word or phrase of this theoretical construct has meaning and builds a composite explanation that addresses the question of what is special about mental health nursing.

*'Being'* has two connotations in this construct. Firstly, it relays the notion of existence or essence of mental health nursing as a distinct identity, and secondly the notion of presence. There was a strong sense of both these notions emerging from the data and reflective of the nature of mental health nursing.

To deal with the first notion, becoming and being a mental health nurse has its foundations in serving others. Along with its specialist professionally based knowledge and skills, the work of nursing is often basic care and as a discipline has had humble beginnings. This is expressed in the modesty of its work and consequently the adoption of humility in its practice. Within a nursing paradigm, the caring process acknowledges and responds to client needs as the purpose and rationale for that care. This is a distinct lens acquired by being a nurse, fulfilling expectations of others in order to improve the health and well-being of those in their care. Nursing is charged with addressing issues outside the remit of other disciplines. This is the essence of the task, rationale and identity of nursing.

Because nursing attends to the health needs of clients, the profession of nursing requires knowledge of health conditions with which they are involved. Nurses undergo a curriculum of study that draws knowledge from a variety of disciplines to contribute to its study of human bioscience. In the case of mental health care, health needs are often imprecise and poorly understood, multi-factorial in their aetiology and, as a consequence, diverse and complex, involving social and cultural as well as biological and psychological issues. The discipline of mental health nursing must meet these challenges in order to attend to their direct caring role in the process of facilitating healing and recovery. Mental health nursing is primed by its broad knowledge base and experience to see these challenges in a holistic way and is

intuitively attuned to meeting diverse needs by practising holistically. This ethos was apparent in the data from mental health nurse participants in this study discussed in section 5.6.1. This identity of mental health nursing, as a specialist discipline, translated into special aspects of the practice executed by them.

This introduces the second notion of 'being' which addresses the phenomenon of presence, or 'being with'. The concept of presence is espoused as a core relational skill in the profession of nursing and was referred to in Chapter 2 in relation to the work of Finfgeld-Connett (2006a, 2008b, 2008c). In an earlier publication, Glass (cited in Hemsley & Glass 1999) describes 'presencing' as 'placing ourselves deeply within interpersonal interactions' and becoming 'connected with each other ... by being there in the moment for them' (p. 27). At about the same time, Walsh's (1999) phenomenological study of mental health nurses' encounters with clients uncovered different ways of 'being in the world with patients' made possible by 'shared humanity'. He asserts that ...

... we, nurses and patients, share a basic understanding of what it is to be human, which allow us to communicate on a deep and primordial level with understanding, possibility and concern. This basic humanity can be covered over, but where it is uncovered it can lead to deep and moving encounters in which the patient and the nurse meet as Beings in the world, as first and foremost, human beings (p. 5).

More recently, McMahon and Christopher (2011), in developing a mid-range theory of nursing presence, identify a number of nurse and client related characteristics that influence presence as well as relational and contextual components. They accentuate, however, the notion of 'nurse-sensitive points' in their encounter with clients where the nurse pauses to consider 'the complex interplay of client needs, nurse ability, and contextual environment factors that determine the eventual dose of presence delivered' (pp. 80-81).

Presence, therefore, is portrayed by the above authors as being with the client in significant relational ways that are responsive and sensitive to interactions induced by the aspirations of both the nurse and the client towards a therapeutic outcome. Mental health nurse participants expressed that these aspects of presence are induced by being a nurse, which means to minister care to soothe, comfort and heal



in direct contact and association with their clients. It requires mental health nurses being engaged in the everyday, lived experience of their clients and understanding how this experience is complicit in their health profile and consequences. This sensitivity to the lived experience of a client's health journey is acquired by purposeful and time intensive contact with them. Mental health nurses learn to appreciate and respect that the lived experience of health issues from the client's perspective provides the potential for, and actualisation of, real solutions to their health challenges, acknowledging the idiosyncratic nature of their health experience. It involves addressing issues of everyday living, which could be executed by anyone. However, the discipline of mental health nursing brings distinct professional knowledge and skill to tasks of everyday living that make them meaningful in terms of therapeutic care and outcomes.

Adopting a life-oriented approach to practice requires a presence in the '*here and now*' with the clients' health experience. Seeing what is relevant 'today' in the real world of their clients is facilitated by this intimate presence, being there in the immediate life of the clients on their territory, physically, psychologically and socially, '*side by side*'. More than this, this process informs it, by both the expressed needs of the clients aided by this closeness, and from experience of this presence itself and the sensitivity it induces to achieve a therapeutic partnership that is meaningful to both parties. Mental health nurses engaged in this process are therefore readily accessible to their clients on a number of levels. The care that results is not merely delivered from a professional perspective, but is '*co-constructed*' from a position that respects, honours and responds to the expertise that both parties bring to the relationship. The special properties of these mental health nursing professional behaviours are outlined in section 5.6.2 of this thesis.

*'Recovery-focused mental health nursing'* demonstrates a willingness to share the power inherent in the notion of expertness, negotiating interventions and contracting the execution of them based on the acquired experience, knowledge and evidence blended from all contributors as experts in that particular instance of health need. It allows practice that is flexible in its boundaries (within professional and statutory constraints), exercises the use of creative interventions beyond a traditionally established evidence-base, and models equilibrium in its professional power relationship with clients and others that is rooted in experience and a world view that

is distinctly nursing. Section 5.6.3 of this thesis explicates the productive consequences of this practice, which is rooted in the distinct nature of being a mental health nurse. It is special!

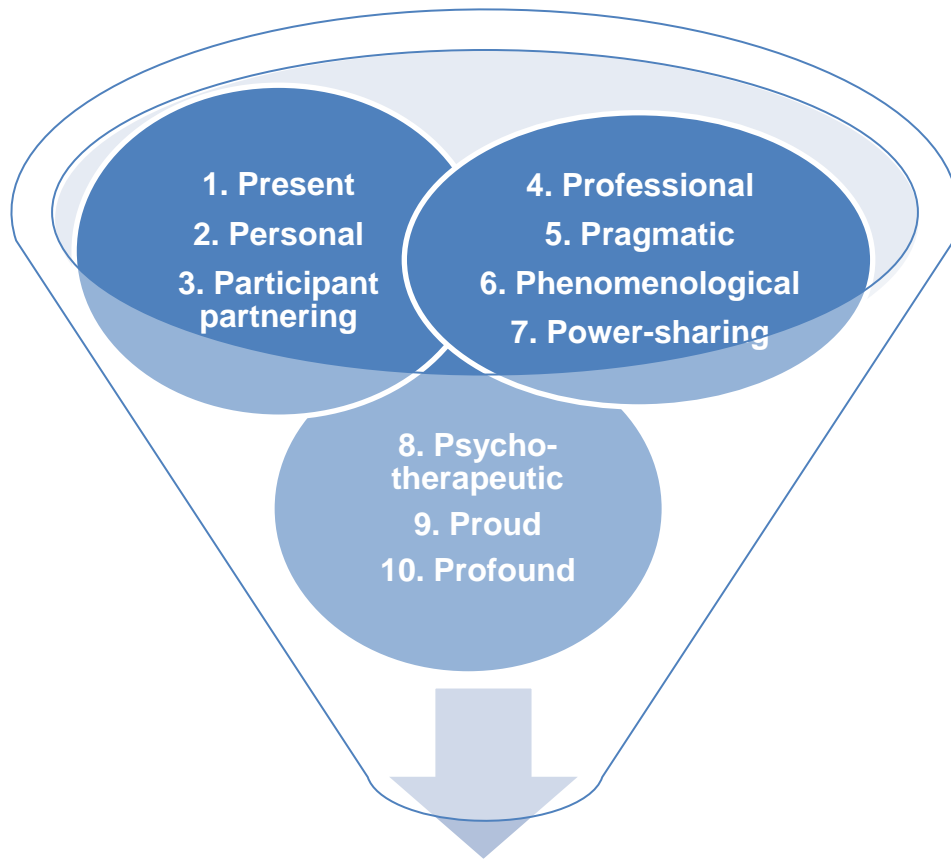
This substantive theory of mental health nursing was constructed from the accounts of actual practice of a particular cohort of mental health nurses. Their stories were analysed in a systematic manner adhering to fundamental methods of grounded theory research as described in Chapters 3 and 4. With increasing sophistication of conceptualisation, the theory was generated and integrated into a single conceptual model that interrelates and links its foregoing categories and psycho-social process. It represents a model of mental health nursing that draws on some concepts well established in the literature. In addition, it draws on new data to expand and revitalise these concepts. It is a product of interpretations related to contemporary practice in Australia, revives notions of therapeutic intimacy, adds meaning to professional interpretations of recovery-focused care and uses the concept of co-construction as the binding mechanism by which mental health nurses relate therapeutically with their clients.

As a theory generated from practice, the challenge now is to articulate how the theoretical construct relates back to practice in a fresh and novel way, providing a model from which mental health nurses can derive meaningful professional identity and describe their discipline by attributing characteristics that represent this identity as distinct and productive.

### **6.2.1 Attributes of recovery-focused mental health nursing practice**

An explanation of being in the here and now, side by side, co-constructing care as a substantive grounded theory of recovery-focused mental health nursing has been provided in the preceding text. The applicability of this theoretical construct requires its elements to be distilled into attributes that reflect how it can be interpreted into practice. To this end, ten attributes of the professional profile that distinguishes mental health nurses have been formulated and are represented diagrammatically in Figure 20.

## Ten P's of the professional profile that is mental health nursing



## Recovery-focused mental health nursing

**Figure 20:** Attributes of recovery-focused mental health nursing practice

The diagram above depicts three interrelated and interdependent entities coalescing to form an integrated phenomenon of recovery-focused mental health nursing practice. The first entity, covering the first three attributes, represents the nature or essence of mental health nursing that guides and determines its practice. The second entity, covering the next four attributes, represents the manner in which practice is engaged in response to this distinct nursing orientation of care. The third entity, covering the last three attributes, represents the outcomes of this phenomenon to deliver recovery-focused mental health nursing.

The nature of nursing, and specifically mental health nursing, allows, and indeed dictates, working first hand with the clients for whom they care. The essence of this hands-on work depends on being *present* with the client to affect that care. *Present*

not only connotes physical engagement, but also the temporal notion of being in the moment, experiencing the immediacy of the client's physical, psychological, social and spiritual being. The intimacy of this encounter engenders a sense of the *personal* for both. For the client, this involves sharing private details of their life. For the nurse, it requires they confront parts of themselves generated by the inherent emotion that this experience brings, and to which they become sensitised in order to provide the empathy and therapeutic action sought by the client. As expressed by one participant:

*"This work is tightly integrated with who I am. It's very personal in that I use my experiences and intuition to guide me in my work and I am open to possibilities. I am aware of the trust I have in myself, in the process and the person I am working with. This in turn helps the client come to trust as well as take risks. This makes it a very dynamic and special relationship and keeps the work fresh and meaningful. I approach my role with passion and all of who I am, and this feels good. I agree that it's intimate work as we strive to be intimately in tune with the client's life and health needs"* (MHN participant 20).

The closeness of the relationship in which this takes place is the nursing care work environment. Therefore, the nurse, while maintaining boundaries that preserve the safety and welfare of the client, is an active participant in the care relationship rather than a distant observer. It is a *participant partnering* that is derived from the nature of nursing work and which is the genesis of therapeutic engagement that allows interventions for care to be co-constructed.

Mental health nursing is *professional* in its foundational knowledge and in its expressed practice. Moreover, beyond comprehensive pre-registration general nursing qualifications, mental health nurses need specialist professional nursing qualifications in mental health in order to apply established evidence-based interventions as well as utilise their distinct position in working with clients to generate alternate sources of evidence for intervention. In this respect, it is epistemic, relating to knowledge. At the same time, it is *phenomenological*, stressing all domains of experience. Inclusion of the lived experience of mental health and mental illness from the client's perspective, as well as the lived experience of the nurse's experience and achievements in this partnership of care, is essential.

Blending professional and experiential knowing based on this participant partnering is an acquired skill and approach to care that characterises the nursing lens.

Mental health nurses' *pragmatic* approach to care facilitates this. Their concern with practical and positive consequences for their clients drives this approach and is in accord with a client-focused and recovery agenda. Dealing with the practical issues of a client's life encourages a broad, holistic view, acknowledging that the ordinary activities of living are interwoven with illness expression that may be either and/or biologically, psychologically, socially and spiritually based or determined. Real and present issues are addressed by a therapeutic relationship that is grounded at the client's current level of readiness and capacity to engage, sufficiently flexible to accommodate change and variance, and purposeful in its therapeutic intent.

*Power-sharing* is also a crucial element that aids this process. The credibility of mental health nursing expertise is not built on prescribing care, but rather on participatory care that creates equity in the power dynamic of the nurse/client relationship. Mental health nurses, in particular, know the empowering effectiveness of participatory involvement in care, facilitating self-responsibility, accountability and ownership of each player's contribution to that care. In particular and in sync with 'recovery' principles, they acknowledge the need for those with lived experience of mental health issues to have influence and control over their experiences in mental health services. It has become a familiar component of nursing practice through constant and continuous rehearsal and reinforced by the benefit and positive outcome that comes from it.

Inextricably linked with these elements are those of presence and participatory partnering in a context of blending the personal with the professional that defines the distinct practice that is mental health nursing.

While the discipline of nursing promotes and implements care across the bio-psychosocial-spiritual spectrum, a specific agenda for mental health nurses is to enhance mental health. Therefore, there is a targeted focus on *psychotherapeutic* outcomes, which is inherent in their remit as specialist practitioners.

Psychotherapeutic interventions are informed by traditional, evidence-based knowledge and practice but in addition, are executed in the context of the nursing paradigm described above and tempered by the needs, wants and aspirations the

client brings to the process. The sensitivity and alertness required to encourage the client to take leadership in their health journey engenders psychotherapeutic benefits through nurses modelling and facilitating empowerment in the relationship. This is a distinct contribution that makes mental health nurses stand *proud* in the context of multi-disciplinary mental health care; proud in the sense of standing out but also in the sense of being different in a confident and distinguished identity that is mental health nursing. The consequences of this special contribution are *profound*, demonstrated by the positive outcomes that this orientation of care brings and adding a credible and distinguished contribution to the meaning and understanding of professional caring relationships.

This model, derived from data that were sought to explore the nature, scope and consequences of mental health nursing, is internally consistent with the aim of this study. Interpretations made from the data at increasing levels of conceptual sophistication have progressively consolidated a theoretical construct that purports a paradigm of mental health nursing practice that also addresses the issues of interest and concern that has driven this study. Its ten attributes provide specific directions to guide practice that is in harmony with a professional nursing ethos, a mental health nursing specialist orientation to care, and an approach that supports contemporary expectations of recovery principles.

While it is acknowledged that systemically the dominant paradigm of mental health care delivery is bio-medically based, it is contested that a bio-medical paradigm is too narrow for effective nursing practice. Therefore, two P's are excluded from the constructed nursing paradigm, and they are 'psychiatric' and 'paramedical'.

Psychiatry, as the practice and science of treating mental illnesses and disorders, is a discipline largely claimed by the medical profession and expressed in specialist medical practice by psychiatrists. Its domain of viewing 'illness in an integrated way by taking into consideration the related aspects of body and mind' (The Royal Australian and New Zealand College of Psychiatrists 2013) does not encompass the breadth of health experience by clients that is attended to by applying a mental health nursing orientation of care. While mental health nursing utilises psychiatric expertise, it is not its only consideration in providing care, particularly care that is in accord with a health journey that is led by the client. As a consequence of this

position, weight is added to the title of this practice as 'mental health nursing' in this thesis rather than 'psychiatric nursing'.

Similarly, the term 'paramedical' is considered inappropriate in the context of the paradigm developed for mental health nursing in this thesis. While it is a term not often used in contemporary parlance, it must be acknowledged that medical paradigms of care are dominant in the delivery of mental health services, as they are in other areas of health care delivery, and paramedical is an implied term for health professionals other than medicos in this context. Even those mental health nurses working in the MHNIP have their practice statutorily regulated under a medical paradigm of care delivery. Nevertheless, the essence of mental health nursing, while serving others, is not subservient in its role and identity. To be so would restrict and constrain the very elements of nursing practice that distinguish it as a distinct and essential contributor to health care delivery. It is, however, co-operative and complementary and while not enjoying the same professional status as some other health care professionals, it is comparable in its professional importance for the services it provides for the ultimate objective of enhancing mental health for both individual clients and the community at large.

### **6.3 Existing nursing theories that inform this study**

Exploration of existing theories can add explanatory power to the theory generated by their association with a theoretical body of knowledge. However, Glaser and Strauss (1967, p. 253) caution researchers not to 'stifle potential insights by virtue of too strict adherence to existing theory'. In concurrence with this notion, Birks and Mills (2011, p. 125) propose these extant theoretical codes should be positioned outside of the storyline to avoid confusion between the researcher's interpretations derived from the data through analysis, and those imported from other theorists. It is for this reason that further research of the nursing theory literature has been left to this point.

Chapter 2 of this thesis discusses the genesis and status of mental health nursing in Australia. Part of this discussion addresses the generic professional identity of nursing as a distinct discipline. Therefore, generic theories of nursing are worth exploring and discussing in terms of their relevance to the theory generated in this

study. In addition, it is argued that the context of care in which mental health nursing operates has distinct features and is specialist in nature. In order to attend to both issues, particular theorists are examined to address both generic and mental health specific issues.

It is acknowledged that there are many more nursing theorists than those referred to here. However, this section has chosen antecedent theories of nursing and mental health nursing on the basis of their relevance to theoretical concepts constructed in this study from participant data. Specific issues of interest and relevance include concepts of caring, models and approaches to practice that address broader life issues, interpersonal relations and their therapeutic impact, and recovery-focused care.

To identify with the nursing discipline in the Western world, acknowledgement must be made of its founder in Florence Nightingale. She is credited with the articulation of the distinct domain of nursing practice as it was in the late 19<sup>th</sup> and early 20<sup>th</sup> century. This included placing the patient as the central focus, and monitoring the environment for its health impact as the context of care in which comfort and healing is promoted through nursing intervention. Her writings about the goals and processes of care, claims Meleis (2012, p. 60), 'are testimony to the potential for nursing as a field of practice to be articulated theoretically'. Nightingale's (1946) 'Notes on nursing: what it is and what it is not', originally written in 1857, sets the scene for a broad landscape that distinguishes the discipline and domain of nursing:

Nursing ... has been limited to signify little more than the administration of medicines and poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet – all at least expense of vital power to the patient. The art of nursing, as now practised, seems to be expressly constituted to unmake what God had made disease to be, viz., a reparative process (Nightingale 1946, p. 6).

Peppered throughout her descriptions of ministrations to patients, there is evidence of cognisance of response and attention to the general and idiosyncratic needs of patients' physical, psychological, social, cultural and spiritual state. It is also evident that the sensitivity required to achieve this is the realm of a professional and ethical approach to care. This is in a context of a relationship that serves the patient with the



intent of health improvement, taking nursing to a level beyond the preceding traditional practices of 'women healers' (Ehrenreich & English 2010). It is opined that the essence of nursing identity, as articulated in these foundational schemata of practice, is still evident in mental health nursing practice as expressed by participants in this study, and illustrated in the substantive theory and attributes of recovery-focused mental health nursing practice as previously articulated.

Almost 100 years had lapsed from Nightingale's time before the discipline of nursing turned its attention to theory development. This grew out of the move from diploma to baccalaureate preparation for nurses in the United States of America. At the forefront of this movement, in the early 1950s, was Hildegard Peplau, who was the first to articulate interpersonal processes as central to nursing from which other theories of mental health nursing developed (Meleis 2012, pp. 68-70). Peplau's work has been referred to in Chapters 2 and 5 in relation to the distinct identity of mental health nursing and the centrality of interpersonal relationships in practice. Her emphasis was on the priority that counselling and psychotherapeutic roles should take in mental health nursing while acknowledging that the operational aspects of mental health nursing involved technical and interpersonal aspects. However, the process of nursing itself, she asserted, was more than technical, and outcomes for patients were influenced more by the human relationship and the interpersonal interactions that ensued (Peplau 1991). She argued that the nurse and not the therapy itself is the agent of change for the client. However, the notion of co-construction emergent as a central premise of the substantive theory, outlined in the previous section of this thesis, provides a different perspective. It purports that it is not solely the nurse's actions, but the coalescence of the nurse with the client, as a dual process, that determines and actions mutually constructed interventions and change.

The notion of co-construction is not so evident in Peplau's thesis; however, it is implied in some of her ideas. For example, the concept of the mutuality of the nurse/client relationship, emerging from a strong client focus to care, is ever-present and resonates with the concepts constructed in this study. She addresses power dynamics in professional interpersonal relations and how 'personal power, and its

counterpart, powerlessness, are important aspects of the recovery<sup>26</sup> process which patients undergo' and urges consideration of 'how more democratic balancing of power can be effected' (Peplau 1953b, p. 1222). In addition she urges nurses to develop methods for 'seeking to know, in contrast to knowing' (Peplau 1953a, p. 1345), adding value to the concept of contracted care from a basis of shared expertise. She alludes to opportunities and attention to negotiating alternative options for interventions using the client as a guide, proposing that a distinct nursing function is 'identifying problematic situations, appreciating and liberating positive forces in patients' personalities' which has mutual benefits where the nurse 'both expands her own insights and helps the patient to grow' (Peplau 1951, p. 723). Peplau (1953a) also reinforces the nurse's function of 'participant-observer' by taking 'part in the patient's continuing struggle to locate, clarify, and solve his problems' and achieving this through self-reflective practice 'to understand the meaning of her own actions, and how her feelings enter into them' (p. 1345), reminiscent of the notion of the 'personal' in professional encounters. She also refers to the perception of the world that the client brings to the relationship and the importance of acknowledging this and taking it into account in nursing interventions. 'When the psychiatric nurse can understand this and can see it in relation to the unique context of the patient's life history', she says, 'then she can begin to plan her intervention'. She also reinforces that these interventions should be paced 'at the patient's rate of movement' (Peplau 1954, p. 327). The mutuality of the nurse/client relationship as a helping one is also expressed by the dynamic of the nurse modelling therapeutic opportunities and insights which 'enables the patient to appreciate the same principles that she (the nurse) makes use of as she exemplifies a helping person to one in need' (Peplau 1951, p. 723).

Peplau (1954) explicates these interactions as central to psycho-dynamic nursing but also emphasises that the relational experiences are 'aspects of the nurses' participation in life on the psychiatric ward' where the nurse's task is 'making these daily events count as learning experiences'. She also alludes to holistic responses to care by responding to 'whole concepts of what goes on rather than fractionalize

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<sup>26</sup> Peplau's orientation in her theoretical positions was in the context of in-patient psychiatric wards and the notion of 'recovery' may well have been expressed as a process of getting better rather than the more recent interpretation of client led care. Nevertheless, the fact that issues of power and powerlessness are addressed may also indicate a leaning towards, at least, addressing the client's role and input in determining the care provided.

nursing practice on the basis of data concerning one particular problem' (p. 328). This sensitivity and therapeutic benefit that nurses bring to the present and broad issues that clients face is also distinctive, according to Peplau:

Nursing, as an applied science, is in a unique position to identify and study the scope, range, and varying intensities of recurring human problems that have to be faced in everyday living. Nurses are also in a position to identify and study degrees of skill that people use in struggling with presenting difficulties and to develop with patients the kinds of new experiences that are needed to improve such skill (Peplau 1951, p. 723).

The lived experience of mental health nursing as expressed by participants in this study has strong resonance with the principles espoused by Peplau. While participants did not specifically relate their practice to Peplau's model of practice, they did relate the unique influence on their practice of working in acute psychiatric wards, which was the landscape from which Peplau derived her concepts. Peplau's broader reference to social and interpersonal psychiatry, as influenced by Fromm and Sullivan, also tempers her thinking to a broader landscape of care, one in which participants in this study executed their practice. It is surmised from this that the experience of mental health nursing has enduring qualities because of its distinct position and placement in the world of the clients they serve, coupled with the challenge of employing these relational experiences with a professional agenda of therapeutic outcomes. Peplau articulated these phenomena explicating some of the essence of mental health nursing that has survived in contemporary professional practice according to the informants in this study and the subsequent interpretations made of their accounts.

Some 30 years on, Barker (1989) provides a conceptual framework, which, he claims, is not a model of nursing but rather a redefinition of his own work as a mental health nurse and psychotherapist. He introduces a notion of nursing 'care' in mental health that 'involves a fusion of the nurse and patient which is more characteristic of the tradition that is art, than of the subject-object duality which characterises traditional science'. He names this phenomenon 'trephotaxis', derived from the Greek meaning of 'provision of the necessary conditions for the promotion of growth and development'. In this concept, caring takes on an 'ecological' position of

acknowledging the 'interaction of the biological, cultural, social and personal 'selves' that are the person', and catering for the individual needs of each client. He frames this within a paradigm that 'involves an acceptance of what cannot be changed, while at the same time responding to the challenge of what needs to be done, in terms of direct action' (pp. 138-140).

Ten years later, Barker and his colleagues (Barker, Jackson & Stevenson 1999) report on their substantive grounded theory seeking to explain the need for mental health nurses. Their core category, 'Knowing you, knowing me', expounds the proposition that nurses 'know' people best, facilitated by the proximity and closeness and time available manner with which they work with clients, and the mutuality of the relationship that fosters active collaboration by 'caring with' rather than 'caring about' (pp. 278-280). They conclude that ...

If nurses are to become legitimate, and valued, members of an interdisciplinary mental health programme, there is a need to clarify, further, what needs nurses meet, that are not addressed by other members of the team. Therein may lie the key to the future of the discipline (p. 281).

From this work, Barker developed a theoretical construct of mental health nursing which he called 'the Tidal Model'. This model embraces a recovery approach to care and addresses issues of empowerment and power-sharing, the critical role of interpersonal aspects of care, as well as notions of interdisciplinary teamwork, holism and acknowledgement of and response to, by mental health nurses, the lived experience of clients in their care. Barker's emphasis on holism, the centrality of interpersonal relations, the key role of a client's determination and participation in their own care, and focusing on problems of living and not just illness (Barker 2001a, 2001b, 2001c, 2003) resonate strongly with the practice of mental health nurse participants in this study.

Other generic models and theories that define and distinguish the discipline of nursing also contribute to the identity that is nursing. For example, Watson's (2012) concept of human caring science is put forward as a distinct nursing phenomenon for the manner in which it works in concert with clients. Of particular relevance in the context of this study is Watson's model of 'Intentional Transpersonal Caring-Healing'. It purports that 'patterns emerge from our practices that are dynamic, energetic, and

actually potentiate the caring-healing field in a given moment', (Watson 2002, pp. 14-15) adding conceptual strength to the mental health nursing attributes of 'present' and 'phenomenological' constructed in this study. Roper, Logan and Tierney's (1996) nursing model, based on models of living, also resonates with concepts of holism, and Orem's (1991) self-care deficit model is notable in terms of concepts that relate to and encompass attributes, as previously described, of 'pragmatic' and 'professional' as entities that form an integrated phenomenon of recovery-focused mental health nursing practice.

These are but a few examples of the myriad models, concepts and theories that have been the focus of nursing inquiry after Nightingale and since Peplau which may add explanatory power to the theoretical construct in this study. It is not the intention here to expound all theories of nursing and their properties for their relevance to the substantive grounded theory in this study. The purpose is to demonstrate that there is a community of ideas and concepts that comes from investigating phenomena through research and coalesce to form a body of knowledge and understanding. Moreover, while the concepts constructed from this study reflect those of antecedent theorists, they also represent a renaissance of central concepts of mental health nursing. This revival is enhanced with additional and novel dimensions from the data reflecting the contemporary context of mental health nursing practice, thereby providing an opportunity for a renewal of ideas and practice that is distinctively mental health nursing today.

In the words of Peplau: 'This is the nature of theory - ever changing, being revised, reconstructed, and made more useful' (Peplau 1953b, p. 1221).

This journey of discovery has gained momentum into the 21<sup>st</sup> century which Meleis (2012) positions in an optimistic and ambitious frame:

We are more experienced, more assured, and more trusting in our perceptions. We are more accepting of the significance of patients' and nurses' experiences and of the varied meanings of experience in the development of nursing knowledge (p. 40).

## **6.4 Consolidation of a theory of mental health nursing in an Australian context**

In the context of a contemporary and ongoing debate about the essence and identity of mental health nursing, this study set out to develop a conceptual framework of contemporary mental health nursing. Specifically, it posed the question 'What's special about mental health nursing' in search of an explanation of the distinct qualities of its practice that affect positive outcomes for whom it serves. To this end, the nature, scope and consequences of mental health nursing were researched. The resultant substantive theory is one that claims loyalty to the data sourced, and explanatory power in terms of the phenomena conceptualised. It also claims to provide a framework of mental health nursing practice that is contemporary in an Australian context which is relevant now and into the future.

### **6.4.1 Meeting the study's objectives**

The study started with five objectives around which the inquiry was framed. The extent to which it has met these objectives is now explored. Specifically, the objectives, as outlined in section 2.4, are addressed.

#### **6.4.1.1 Objective 1: To explicate the essence and nature of mental health nursing and its scope in a contemporary context**

It is argued that much of the focus of this study has been the essence and nature of mental health nursing and its inextricable link with, and determining the scope of, its practice. This was a natural assumption and place to start assuming that any discipline's practice is bounded by its foundational characteristics. In the case of mental health nursing as expressed in this thesis, its genesis is found in generic nursing principles of care adapted to the specialised field of mental health. Specialist mental health nurses working in a contemporary and largely community health settings were chosen to inform this objective. Their contribution not only provided descriptions of practice, but afforded the opportunity for me to interpret these descriptions and formulate concepts of the nature and scope of their practice that focused on its distinctiveness. The resultant constructed hypotheses encapsulate the essence of a nursing bias of care with which participants identified. The

interpretations made to develop the hypotheses were confirmed by participants as accurate and relevant to their practice as expressed in their accounts of their work.

#### **6.4.1.2 Objective 2: To identify the particular contribution of mental health nursing in the context of its impact on improving client care and outcomes**

Part of the construct of this study was framed around not only mental health nursing practice, but also on its impact for the persons it served. Evidence within and outside of this research confirms positive client outcomes as a result of mental health nursing activity in the context of the setting in which this study is set. The hypothesis formulated not only addresses direct benefits to clients, but also the benefits from the inclusiveness and coordination of care that nursing facilitates through its partnering and collaborative efforts, thereby enhancing its positive service to both clients and other care givers. In terms of its place in the context of multi-disciplinary care, the resultant model of care is distinctly nursing, non-competitive with other professions and disciplines, and provides a conceptual framework that espouses its complementarity to other paradigms of care.

#### **6.4.1.3 Objective 3: To justify the claim that specialist education and training in mental health nursing should be the minimum standard for an adequate workforce**

All mental health nurse participants in this study had specialist qualifications in mental health nursing which was an essential criterion for participation. There was no comparison with the care that nurses, without such qualifications, provided. The purpose was to elicit data on practice that was informed by specialist training, education and experience in mental health nursing. Participants were engaged in autonomous practice where the mental health challenges with which they were confronted were often complex and where there was an expectation by referring care providers that a specialist service would be delivered. Their orientation to care was clearly mental health specialist in nature. It was evident from participants' recounts of their experiences that it was guided by a deep and essential knowledge of mental health issues that brought insights into this practice that could not have been afforded from generic nursing knowledge alone.

#### **6.4.1.4 Objective 4: To add to the positive identity of mental health nursing by facilitating an understanding of it as a professional discipline by others**

The hypothetical constructs of the major categories formulated from interpretations of participant data, their conceptualisation into a core category, and outline of a psycho-social process explains distinct characteristics of mental health nursing. Ultimately, their formulation into a substantive theoretical construct provides a staged and evidenced explanation of mental health nursing in the context examined. The substantive grounded theory that results follows a journey from the question of what is special about mental health nursing, to a clear explication of the distinct contribution that distinguishes mental health nurses in their position to affect recovery-focused care. The adoption of a recovery approach to care by mental health nurses is relevant as a contemporary paradigm that is broad and inclusive in its scope and special for the recipients of that care. The substantive theory generated distinguishes mental health nursing for its orientation to care, recognisably portrays the specific remit of nursing in its application, and therefore identifiably represents practice that is different from the application of other disciplines. Explicating this distinct practice and its ten attributes provides a framework of explanation for others, who have access to persons requiring mental health care, to understand and utilise the specialist and distinctive skills that mental health nurses offer.

#### **6.4.1.5 Objective 5: To provide an explanation of distinctive mental health nursing practice irrespective of the practice setting in which it occurs**

While mental health nurse participants in this study were providing and reporting on care in particular settings that are not representative of the settings in which the majority of mental health nurse work in Australia, they were still practising mental health nursing. The aim of this study, consistent with grounded theory studies, was not the representativeness of the participants in relation to their colleagues, but the explication of the phenomena of interest that have driven the inquiry. It has been argued that the latter outcome has been satisfied. The setting in which the participants in this study practiced is relevant in terms of its encouragement of, and



opportunity to, express the broad practice potential for mental health nursing within its statutory and ethical boundaries. Criteria for participation were deliberately cognisant of this aim in order to solicit the greatest depth and breadth of information about possible practice within the scope of mental health nursing practice. That is, to elicit explanations of practice that could work to the edges of professional boundaries but not outside of them. It is therefore asserted that the substantive theory and model of practice espoused provides an exemplar of practice, based on theoretical and experiential knowledge, that is quintessentially mental health nursing and potentially applicable to any care setting.

#### **6.4.2 Contributing to new knowledge and understanding**

There are two other additional questions that need to be asked of this research study in order to satisfy its purpose and aims. These are, what characteristics of mental health nursing in this study have hitherto not been explored or have been under-explored, and, what is the substantive new knowledge and understanding obtained about mental health nursing in a contemporary context?

Many of the concepts formulated in this study are familiar ones in the nursing and other literature. For example, concepts of holistic care are often referred to as distinctively nursing in orientation and application. Similarly, the nexus of art and science, using and adapting empirical and metaphysical knowledge, and concepts of caring and presence are eloquently articulated by a number of authors and theorists previously referenced in this thesis. Therefore, this study cannot claim originality in relation to these concepts alone. It does claim, however, a novel perspective of mental health nursing in the way in which these concepts interrelate, correspond and coalesce. It brings together individual and identifiable concepts of care into a frame that provides a wholesome concept of mental health nursing in the context of the relationship with those whom mental health nurses serve.

The core concept of '*co-constructing care*' brings a new dimension of service delivery that is inclusive and grounded at the client level. It is supportive of contemporary and innovative approaches to care that are in line with consumer-based principles of recovery', and in sync with nursing principles of care.

In addition, incorporating notions of therapeutic intimacy and the blending of the personal with the professional, '*being in the here and now, side by side*', as an intentional and integral paradigm that facilitates nursing work in naturalistic settings, are products of a special lens that is mental health nursing.

Claims of the research process and outcomes for its rigour, credibility and relevance are explored in the following and final chapter.

# Chapter 7

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## ***Discussion and Conclusion***

This chapter is the ultimate one for this thesis and provides an evaluation of the research process engaged, its attention to quality, and some of its special features and outcomes. It also discusses its limitations, its implications and impact on mental health nursing, as well as other areas of research that are relevant to this study that could be explored. Finally, I will offer my personal reflections on the study and its process before my concluding remarks.

### **7.1 A reflection on the use of Grounded Theory for this study**

The decision to use grounded theory for this study was influenced by two factors. Firstly, I had used the method previously in a research Master of Nursing degree and was therefore familiar with it. Secondly, I wanted to go beyond descriptive methods towards theory generation in order to explore the phenomena of interest at higher levels of conceptualisation than afforded by description alone.

My first foray into grounded theory took place between 1992 and 1996 over the course of the Master of Nursing degree. The method used was largely based on Strauss and Corbin's (1990) schema in an era prior to the strong emergence of the constructivist approach to grounded theory. Nevertheless, using the method did reinforce many of its essential elements and lent an appreciation for its contribution to qualitative research, particularly in its emphasis on conceptualising and generating theory grounded in the data sourced. In retrospect, it was a naïve application of the method, albeit acceptable at the time for the degree to be awarded.

In the pursuit of the present study, it became quite apparent that the grounded theory method to be used required a comprehensive review. The discourse on grounded theory has grown significantly since 1996 and its use demanded extensive investigation of the discussion in the literature and consideration of the best methodological fit for the phenomena of interest in this study. In addition, there was considerable attention in the literature paid to issues of rigour and credibility and the

need to clearly declare one's position in relation to these issues in light of the particular study undertaken. In the process of researching the literature, I came to appreciate that concepts, ideas, opinions and assertions are developing all the time, some expressed better than others and some more authoritatively than others, either by reputation and/or by scholarly application. The debates around the application of grounded theory demonstrated a diversity of opinion and perspectives in applying this methodology that reflected a cacophony of realities. While it presented conflicting and sometimes confusing perspectives, it was also encouraging in that it launched me in to a position of participating in the process of debate and discerning the pertinent application of grounded theory for this present study. At times, the temptation was to revert to a method that appeared the most straightforward for ease of implementation. However, my commitment to executing this study in a manner that would yield faithful meaning to the area to be explored, drove me to critically examine my motives for the research, its expected outcome of theory generation and, doing justice to the potential participants and the issues of concern.

The epistemological aspects of grounded theory and the ontological determinants for using a constructivist approach are outlined in Chapters 3 and 4. Having established an ontological position, I also had to be prepared to live with uncertainty in order to use a grounded theory method. Not being able to second guess the outcome of the research, and relying on faith that the data would reveal the basis for pertinent and creative concepts and eventually theory development, induced some anxiety, considering the significant investment of time and energy committed. However, I confidently worked with the data from which I allowed the concepts and theory to develop and coalesce. Being reflexive about the process, and my relationship with the research, provided an invigorating and mysterious quality that comes with such a journey of discovery. So I learned to appreciate and value the uncertainty as an asset.

The other salient lesson was that real understanding comes with practice. Deeper and more meaningful understanding came when I immersed myself in the process of doing the research itself and achieved a level of understanding that did not occur in the same way until that point. Investing the time in critiquing the methodology and method in order to be as certain as I could that my choice was the best fit for purpose, provided a constant guide and cross check in applying the method to this

research. As a consequence, I was reassured that the choice of grounded theory was the right one and the constructivist approach served to assure me of its integrity in terms of being faithful to my own values and beliefs and to a credible grounded theory process.

As initially predicted, other methodologies would not have satisfied my aspirations for the study's outcome. The specific detail of quality assurance in this process is the subject of the next section.

### **7.1.1 Credibility and rigour**

As explained in sections 3.2.2 and 3.2.3 of this thesis, and detailed in Appendix 2, a set of criteria for credibility and rigour was established to assure and self-evaluate the quality of this research process. These criteria not only provided the means to retrospectively self-evaluate the process, but also to prospectively and continually remind me of the quality issues that needed to be adhered to throughout the research process. Each of the established ten criteria is addressed in the following sub-sections.

#### **7.1.1.1 Researcher expertise**

Researcher expertise is judged on the basis of demonstrated skills in scholarly writing and evidence that the researcher is familiar with grounded theory methods.

Scholarly writing is ultimately judged through examination of the thesis.

Nevertheless, I have been able to demonstrate such writing in previous academic pursuits over 30 years. The standard for research at this level is higher, and has been concertedly reviewed and critiqued through regular, frequent and consistent supervision by two highly engaged and expert academics both with professorial status. Due diligence has been given to writing standards set by the University of Tasmania, aided by specific topics on academic writing undertaken in the compulsory requirement of the Graduate Certificate in Research as part of the higher degree program which I have completed. In addition, attention has been given to produce a writing style that is coherent and easily understandable to any level of reader who may wish to access the thesis.

As previously stated, significant time and effort was expended to understand grounded theory methods in all its connotations. I can confidently claim familiarity with this literature as well as the application of two grounded theory methods in my Master of Nursing degree and in this PhD study. I am also aware that familiarity can breed complacency and continuing review and critique of grounded theory method is productive. The debate about the proper application of grounded theory methods has been wide and extensive and, consequently, ideas have evolved. This critique and pursuit of enhanced thinking is critical to contemporary and future research endeavour in this area. For this study, my choice to apply a constructivist approach to grounded theory was reasoned by my researched understanding and review of the methodology that facilitated a deeper appreciation of the relevance and application of this method for my particular study and for future studies with which I may be involved.

#### **7.1.1.2 Methodological fit for purpose**

Two factors are addressed here. One is the philosophical position taken that fits the methodology and the other is clarity in how the methodology was applied.

My philosophical position in relation to the chosen methodology is articulated in sections 3.2 and 3.3 of this thesis. These sections provide a rationale for the importance and relevance of symbolic interactionism to this study's purpose along with the choice of a constructivist approach for its notions of relativity, subjectivity and co-construction.

These philosophical positions taken have been a potent factor in the research study and are intertwined. Being self-assured of the compatibility of symbolic interactionism with grounded theory as it was originally expounded, and its significance in a constructivist approach, allowed me to be confident that I was pursuing grounded theory with a legitimate philosophical credential. I appreciate, and indeed explicate in this thesis, the counter arguments of the need for one particular philosophical stance such as symbolic interactionism. The epistemological debate, however, needed to be tempered by ontological determinants, which are addressed in the thesis. The imperative to conjointly consider the epistemological and ontological aspects was spawned by a commitment to engage participants in a purposeful manner that was in accord with my own values and world view. In the

parlance of symbolic interactionism, interviews were conducted with participants interactively in a mutual relationship in the natural field to investigate their behaviour and that shared symbolic meanings of reality and were defined through interaction between and among the researcher and participants in the context of the phenomenon of interest. A constructivist alignment to this philosophy is apparent and expressed in the emergence of co-construction early in the research process for this study as explained in section 3.4 2. The notions of constructing and co-constructing meaning from human interactions are also evident throughout the study. This takes particular expression in the data analysis that facilitated conceptual development that identified major categories and their properties, consolidated these into the core category, and expanded and explained these in the psycho-social process and ultimately by the highest level of conceptualisation in the resultant substantive theory. The philosophical underpinnings provided a frame for interpretation of data from participants, and emerged as persistent themes in the data analysis, both of which, it is argued, are testament to the right choice of methodology for the right purpose.

Application of the methodology used in this study is outlined in Chapter 4. Specific features of grounded theory methods in relation to data collection and analysis, sources of data, sampling, theoretical sensitivity, memoing, concept development, and integration and generation of theory are outlined, referenced with significant contributors and commentators on each. Utilising the work of antecedent grounded theorists within a frame of a constructivist approach, a schema for applying the methods was consolidated and explained in Figure 4. The process of building a composite schema was important for two reasons. Firstly, I needed to be sure that the methods used were based on the methodology adopted, that is, faithful to both grounded theory as a general method and constructivism as a specific approach. Secondly, the evolution of applied grounded theory has evoked different schema that can be confounding. Therefore, I also needed to sift through these and express the methods in ways that had understanding for me as well as being clear and concise for the readers of this thesis. I used my composite schema to continually guide and cross check my progress through data analysis, concept formation and development and into theory generation, providing assurance that the methods applied were consistent with the methodology and in their execution.

### **7.1.1.3 Design and method**

Having established the methodology and methods, the design of the study that mirrored these foundational components is outlined in Chapter 4. The purposive sample of mental health nurses, with prescribed criteria for inclusion, was designed for its synchronicity with the assumptions and purpose of the study. It yielded an extremely positive response to participant recruitment. Having achieved a potential recruitment pool three times the number of eventual participants, confirmed that the proposed inquiry, as explained in the invitation to participate (Appendix 16), and the target sample represented a good combination to support the study's inquiry and is testament to its design.

Demographic data were obtained from mental health nurse participants only. This data afforded sufficient information to portray a profile of these participants that placed them meaningfully within the context of the study, as outlined section 5.1.1 of this thesis. The demographic data form (Appendix 8) was designed to be easy to complete by the participant however, on collation of the data, some responses to particular questions were not clear in their meaning. Retrospective clarification with some participants was required to remedy this in order to provide consistently accurate data. Better design of the form and improved quality crosschecks of the data when completed would most probably have avoided this problem. Despite this, the characteristics of this sample are consistent with the intended profile sought to best inform the inquiry, through set criteria for inclusion.

Similarly, the use of semi-structured interviews, predominantly face-to-face, provided the medium desired to obtain a depth and breadth of data pertinent to the inquiry. While face-to-face individual interviews were preferred, the one focus group of four participants and the telephone interviews of three participants did result in the depth of engagement required to provide satisfactory richness of data.

Of the 42 participants in total, only one preferred the option of a survey questionnaire (Appendix 9) rather than personal interview. Responses to this survey were brief, largely dictated by its design of five open-ended questions. This did not allow adequate exploration of the nuances in the responses as the particular respondent concerned preferred no follow-up dialogue. As a sample of one, it cannot be determined how useful the questionnaires would be as an alternative source of data.



Nevertheless, the strategy to have an alternative form of obtaining data was successful in one case and data were obtained that would otherwise have been lost.

#### **7.1.1.4 Data management**

Security of data was managed as described in section 4.11.3 and in the application for ethics approval. Issues of privacy and confidentiality of data were also reinforced when negotiating and undertaking interviews, highlighting specific reference to privacy provisions in the information sheets and consent forms (Appendices 11, 12, 14, 15 and 16). No ethical issues arose in the course of the research concerning data or any other issue.

In relation to organisation of interview data and their analysis, the 'NVivo' software used provided convenient storage facilities but also aided ready access and reference to the data so that its volume did not become overwhelming. All transcribed interviews were migrated to the software for analysis. I used it to develop and store themes, or nodes, which were reduced to subcategories through increasing levels of conceptualisation to finally form the properties of the major categories. A screen shot of the software, as it was used in this process, is included in Appendix 17. It was also the repository for memos and any other significant documents related to participant data. While there is a facility to store and analyse quantitative data in the software, this facility was not used. Instead, I used a spreadsheet to collate and analyse the demographic data collected. Use was also made of text searches in the data, which aided the process of constant comparative analysis used in grounded theory. This was the extent to which the software was used acknowledging it has many more sophisticated features for data analysis that were not accessed because I had only a naïve understanding of the software. However, I am confident that the analysis that was undertaken was able to capture the richness of the relevant data.

'Endnote' software also assisted the research process particularly in relation to theoretical sampling of the literature to enhance understanding of the developed categories and their properties. The ability to use key words in the software to search for themes in the literature not only made the task easier, but also provided reassurance that relevant information was not overlooked.

### **7.1.1.5 Data analysis process**

The process of analysing participant interview and survey data in this study is described in sections 5.2 to 5.8 in this thesis. It is portrayed as a progressive process moving from initial coding, concurrently collecting and generating data, making memos about ideas and hunches about the data while constantly comparing sets of data with other sets and checking out these embryonic ideas about the data with participants through the Progress Bulletins. This was not a lineal process but more a circular one, where the timing and sequence of these processes would vary according to how concepts were emerging and how the data informed these. The analytical focus remained very much on data from participants in the first instance in order to ensure that the emerging concepts were grounded in, and based on, this source.

Once the three major categories and their properties began to take shape, then the imperative was to theoretically sample the literature to question the constructed concepts more fully. The commitment to treating the data and the grounded theory method fairly towards the goal of generating theory was very strong at this point. I needed to reassure myself that this was being executed in the best possible manner and I employed a number of strategies to assist this.

Firstly, I held tightly to the 'general wonderment' of the study about providing an explanation of what is special about mental health nursing. This helped preserve the milieu of questioning, rather than providing answers, which I employed deliberately in order to ensure all avenues of inquiry were pursued before jumping to conclusions.

Secondly, constant reflection on my interaction with and interpretation of the data was vital. For example, the preliminary literature review revealed issues about the bio-medical dominance of health, and by association, of nursing. It also referred to mental health nursing identity issues providing uncertainty about their role and by implication, a diminution of it. Further, it also posited that mental health nurses were victims of stigma by mere contact with those who endure the stigma of their mental illness. I had also worked in public mental health services for nearly 40 years. Over that time, I had witnessed and endured some of the powerlessness that these factors can generate. Therefore, there was an expectation on my part that the data would reveal issues that reflected this position of subservience and powerlessness as a

factor in how mental health nurses behave in their interaction with clients. It was an essentially negative preconception without form or evidential substance other than anecdotal inferences. When I wanted to describe this phenomenon, I looked to the data for the clues but could not find them. Instead, what I found was a positive connotation of this issue that was eventually re-framed into the concept of the therapeutic value of serving others. This was articulated in the hypothetical construct of one of the major categories 'Using the distinct nature of mental health nursing in the service of others'. This self-reflective process took due diligence to maintain as it is essentially a personal and lone process, albeit augmented by good supervision, because you alone know the data best and therefore have to bear the responsibility of ultimately being true to it.

Thirdly, the use of gerunds to describe phenomena provided a turning point in conceptual development and was crucial towards understanding and developing my conceptual thinking towards a core category and psycho-social process. A fellow PhD candidate, using grounded theory, presented the progress of his work and provided a clear explanation of the derivation of the psycho-social process in his study. His work inspired me and gave me a clear understanding of what a psycho-social process should look like in a grounded theory. It also reinforced that a psycho-social process is inherently interactive and so using gerunds, or action words, in labelling the emerging concepts took on real meaning. The importance of the philosophy of symbolic interactionism began to become real as did the notion of co-construction. As Charmaz (2011) says:

By using gerunds to code for actions, grounded theorists make individual or collective action and process visible and tangible. Gerunds define actions and enable grounded theorists to envision implicit actions and to identify how they are linked (p. 367).

The above strategies were not isolated revelations but came from my knowledge of some of the key tenets of grounded theory method. However, my full understanding of their application did not come until immersion in the data and conceptual development demanded it, triggered by crucial points in that process. It emphasised for me the importance of understanding, attending to, and making transparent the

mechanisms to maximise the credibility and rigour of a grounded theory study. It not only helps to defend the study in retrospect, but indeed facilitates the process itself.

I am therefore confident that my analysis of the data was cognisant of and faithful to a constructivist grounded theory method that was thoroughly and diligently applied. Without such self-reassurance, I could not have justifiably claimed the veracity of the substantive theory that came from it.

#### **7.1.1.6 Data authenticity**

Data authority is determined by the range of data and observations contained within them to satisfy the claims made. Authoritative data also allows the reader to form an independent assessment of the claims in order to agree with them. This quality aspect of the grounded theory process is essential in the initial formulation of categories because this is where foundational concepts are established to encourage and execute increasing refinement through higher levels of conceptualisation towards theory generation and integration.

This is most apparent in sections 5.6 and 5.7 of this thesis and consolidated in Chapter 6. To capture the essence of the properties of each of the categories, statements, derived from participant data, were expressed as gerunds and used for headings. Within each property, an interpretation of the derived data was supplemented with excerpts from participants and, where appropriate, from the literature to add explanatory power to the concepts. They were also represented in graphical and tabular form to enhance understanding of the interaction and relationship in and between the categories and their properties. In addition, this detailed explication was summarised into Progress Bulletins that were disseminated to participants for feedback and comment, the responses from which were used as additional data to enhance the meaning of the developed concepts.

In particular, positive affirmation from participants about the final Progress Bulletin (number 17) was most reassuring. This Bulletin provided an explanation of the substantive theory developed and the affirming feedback came on the back of strong identification by participants with the concepts that preceded it. For me, this indicated that my respect for credibility and rigour in the analysis process had rendered data that supported the concepts derived from it.

#### **7.1.1.7 Research outcomes**

The quest in a grounded theory study is not only the production of a substantive theory, but also to know whether the research has achieved intimate familiarity with the phenomena of interest in the context in which it occurs.

From a personal perspective, as the researcher who has spent a considerable amount of time absorbed in and focused on the phenomena of interest in this context, I can justifiably claim intimate familiarity with them. I also contend that my passion in executing this piece of work has captured the imagination of a substantial part of the mental health nursing community. From the outset, the response to expressions of interest to participate was most encouraging. Throughout the course of the study, presentations of the research progress at local, national and international conferences saw good attendances and ready acquiescence by attendees to receiving the Progress Bulletins to keep the interest alive.

#### **7.1.1.8 Originality**

Originality requires that the analysis provides a new conceptual rendering of the data and that categories are fresh and offer new insights.

As already stated, data analysis initially involved and was sensitive to participant interview data providing unique data in a specific context. This original data led the formulation of concepts augmented by the literature where relevant. That is, the conceptual frames and models emanating from this process were based on new data. It is acknowledged in section 6.4.2 that singly, some of the concepts cannot claim originality as they have been expressed and explained by other commentators. However, these concepts, in the context of the substantive theory developed, play an integral and interactive part in contributing to a wholesome concept that reflects the distinctiveness of mental health nursing in a particular context. Novel concepts around co-construction and therapeutic intimacy in a recovery frame, for example, do, I contend, offer new insights.

#### **7.1.1.9 Transferability**

This study was conducted with a purposive sample in a particular context. Relying on feedback from participants, the grounded theory makes sense to them and has

certainly offered affirming and renewed insights into their world of mental health nursing. Whether other people experience the same understanding and insight has not been tested and provides an opportunity for future research.

Acknowledging the overarching limitation of a specific sample, implications in the explication of categories include nuances and underlying meanings that suggest some generic processes. For example, the expression of the major categories in the core category of co-constructing care towards recovery, incorporating notions of the special blending of nursing art with its science, can be imagined operating in any care setting. The fact that these concepts were generated in the context of mental health nurses working in a particular setting does not detract from the fact that they were reporting experiences based on their nursing practice.

#### **7.1.1.10 Usefulness**

The usefulness of a grounded theory is based on whether it has social and theoretical significance, has generated challenges, extends, and/or refines current ideas concepts, and practices, and whether it can spark further research in other substantive areas and if it contributes to knowledge.

It is asserted that the substantive theory developed in this study, while reflecting concepts of antecedent theorists, represents a renaissance and renewal of central concepts of mental health nursing with additional dimensions and knowledge reflecting the contemporary context of its practice. It is hoped that such an assertion will stimulate vigorous debate and the impetus to pursue advancement of ideas about the special contribution of mental health nurses to positive client care.

The limitations of this research and its implications for various aspects of mental health nursing are discussed in sections 7.2 to 7.7.

#### **7.1.2 Theoretical saturation**

Of special note in reflecting on grounded theory method is the issue of saturation. In common qualitative research parlance, data saturation occurs when no new information is forthcoming from the data sources. 'Saturation' is also used in a grounded theory context to denote the point at which one stops collecting new data (Hood 2013, p. 161).

According to O'Reilly and Parker (2013), grounded theorists go beyond the concept of data saturation to that of theoretical saturation, about which they clarify:

The original meaning of saturation pioneered within grounded theory, of theoretical saturation, is still used within this approach in current work and has retained its central importance. In grounded theory the notion of saturation does not refer to the point at which no new ideas emerge, but rather means that categories are fully accounted for, the variability between them are explained and the relationships between them are tested and validated and thus a theory can emerge (p. 192).

Birks and Mills (2011) also propose that integration of theory relies on saturation of the major categories and theoretical saturation depends on the proper use of theoretical sampling 'to ensure a diverse range of data'. In addition, they suggest that 'as analysis in grounded theory continues until formation of the final theory, theoretical saturation will probably not be truly achieved until your study is complete' (p. 115). They consequently define th

at theoretical saturation occurs when 'no new codes are identified pertaining to a particular category' and 'categories are clearly articulated with sharply defined and dimensionalized properties' (p. 176).

Such was my experience in this study. I found that, in the development of each major category, I continually needed to go back to the interview data for reassurance that all relevant data had been captured and accounted for, and no new data were forthcoming. This commitment was also satisfied with continually consulting the literature as part of the theoretical sampling. It was not until I was assured that each category was 'saturated' and that there remained no conceptual gaps within and between them, that I was able to move my conceptual thinking towards theory generation and integration. My understanding was that this was in proper accord with grounded theory method and it intuitively felt like the right progression. As a result, the generation and integration of the ultimate substantive theory flowed naturally, built on the solid foundation of the conceptual development that had preceded it.

### **7.1.3 The use of Progress Bulletins for quality assurance in grounded theory research**

A special feature of and unique to this research study is its formulation and use of Progress Bulletins. This occurred early in the research process for the purposes outlined in section 4.5. They fulfilled their expectations for me in this study and I would contend that their use is compatible with grounded theory method and could be used as an innovative tool for any qualitative researcher to facilitate crucial elements of the research process.

With particular reference to grounded theory method, two elements vital in theory generation are an accumulated store of memos on which to rely for conceptual development, and for quality purposes, an audit trail of developing ideas towards theory integration. Progress Bulletins provide both. Even a quick scan of the Bulletins depicts the developing story of this grounded theory study providing an artefact of the concepts as they were developed from the data. At the same time, they provided an easily accessible medium to disseminate the findings of the research in progress. Psychologically, this reinforced for me a sense of accountability for reporting findings grounded in the data knowing that many of the recipients were informants for the study. It also required the ability to face the prospect of critical appraisal of ideas that were not firmly consolidated and therefore not easily defended, but I viewed this as a mechanism for scrutiny that is, and should be, part of assuring quality in research. As such, they were a great aid and I would posit that their use is an innovative adjunct to grounded theory method.

## **7.2 Limitations of the study**

At the outset, this study designed its primary informants as mental health nurses. The design also included other informants, namely clients and others who had some engagement with mental health nurses and could comment in a meaningful way on the work they provided. It was anticipated that these differing perspectives may illuminate the topic of research, as well as a new avenue of voice through consumer participation. As reported, there were five clients who participated and one health care colleague. The design also insisted, in accordance with the ethics protocol, that other participants would be at the invitation of the mental health nurse participant



only, which inhibited more aggressive recruitment and engagement of them alone. The data derived from other participants most certainly added value. The extent to which more interviews would have yielded richer data is now open for speculation only. In retrospect, the research design could have either solicited these participants separately or excluded them entirely. Again, this argument now becomes an academic one as the deed is done. It does, however, provide some impetus for exploring and examining these perspectives in other research contexts.

The data, therefore, were largely derived from mental health nurse participants in the form of self-report, self-description of their practice. This was prompted by questions designed to explore the special nature of their practice. Its focus, in exploring distinct contributions to care that effected positive client outcomes, was intentional and designed to emphasise strengths in practice and the tenor of these questions was one that accentuated this. For instance, scenarios depicting negative outcomes or challenges that defeated the expertise of the participants were not explored. For some interviewees, there may have been social and/or professional desirability to 'look favourable', thus leading them to exaggerate their stories in order to make the ability to craft what is special about mental health nursing. However, the use of Progress Bulletins, designed to summarise research processes<sup>27</sup> and findings as they developed, offered a transparency such that it allowed participants and the profession more widely to consider and scrutinize stated claims against a backdrop of real world situations. This strategy helped eliminate the possibility of some participants overtly seeking to portray themselves in a positive light or in a professionally acceptable fashion through the formative and open way in which data were discussed. Reassurance can be taken in the fact that there was no criticism or scepticism of the concepts developed from the data, as reflected in the Progress Bulletins, from participants. Indeed there was strong resonance with the interpretations I made of the data in relation to their practice as they had described it. Similarly, while there were only a few comments from the wider audience of non-participants who received the Bulletins, these did not contain critical comments about the concepts presented. This was also the experience of feedback from audiences at conference presentations in relation to the research, and in particular, the most

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<sup>27</sup> Specific references to grounded theory research methods are addressed in Progress Bulletins 1 (Figure 3), 7 (Appendix 20), 8 (Figure 13), and 16 and 17 (Appendices 26 and 27 respectively).

recent presentations that gave an overview of the consolidated concepts and tentative theoretical constructs. The combined elements of interaction through the research approach incorporating the Progress Bulletins throughout data analysis and theoretical development certainly added value and were formative in the way that key concepts were developed. Even so, this invites further research on aspects of the nature of mental health nursing practice other than those explored in this study.

While it is suggested in the findings that the attributes of distinct mental health nursing practice identified may be applicable across a diverse range of practice settings, a definitive position on this cannot be drawn because of the limited setting in which this was explored. The findings are therefore more aspirational than they are definitively practical in a range of settings, and as a consequence, open to be rendered as lacking authority for those seeking a formula for practice in a particular practice setting that differs from the context in which this study was situated.

Also, the theoretical nature of the research may provide limitations in its influence. The purpose of the research was to provide an explanation of the essence of mental health nursing as a distinct identity. Mental health nurses engaged in and pre-occupied with clinical practice may not be oriented towards being informed by a piece of work that is theoretical in design and application. Abstract concepts and the very notion of theory present a very different way of thinking about the discipline from the practical everyday challenges of clinical work. It could therefore be interpreted as impractical to their concerns rather than in support of it, and so the very nature of the study may be perceived to have minimal relevance to them. On the other hand, credibility of the findings could be assumed through the fact that the theoretical constructs came from interpretations and conceptual development about real and contemporary mental health nursing practice, albeit largely confined to a particular practice setting.

### **7.3 Implications for mental health nursing practice**

The preliminary literature review undertaken to formulate the inquiry for this study identified a need for models of mental health nursing based on its practice. This aim has been achieved by generating and integrating a theory of mental health nursing incorporating ten elements of recovery-focused practice and informed by suitably

qualified, skilled and experienced mental health nurses reporting on their practice. Studies such as this potentially reinforce how practical knowledge and experience can, and should, influence and generate theoretical and practical knowledge that is applied and interventionist. This creates an opportunity for theoretical knowledge to be applied back into practice in other settings.

The substantive theory, and its ten attributes of the profile of mental health nursing and its practice, highlights aspirations for recovery-focused care, collaborative partnerships, inclusive and accessible care, and a special person-centred approach that utilises relational skills as its core. National agenda in Australia for improvement and reform of mental health service delivery, as discussed in Chapter 2, have similar aspirations. This potential synchronicity of aspirations augers well for acknowledging the special place of mental health nurses in meeting these agenda.

Specifically, 'being in the here and now, side by side, co-constructing care' provides a model of 'recovery-focused mental health nursing' along with exemplars of distinct professional behaviours as described in the major categories and their properties. This provides an opportunity for mental health nurses, with the willingness and motivation, to interpret and adopt these concepts into their practice in their particular setting. It is asserted that engaging models of care, that meet agenda at the professional service delivery level as well as at levels of organisational management and development, is not only wise in terms of coherence of service delivery, but also desirable where such care potentially improves positive outcomes for the clients of that care.

There is a well-established methodology for practice development<sup>28</sup> in healthcare that incorporates principles that are compatible with the concepts generated in the substantive theory in this study. These include concepts expounded by McCormack, Manley and Titchen (2013) of person-centred care, using evidence from and in practice, integrating creativity with cognition to blend humanistic with professional approaches to care, and involving internal and external stakeholders across health care teams to develop skills to be implemented as near to the interface of care as possible. Having access to a practice development methodology and/or developing a

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<sup>28</sup> The first concept analysis of practice development was published in 2002 (Garbett & McCormack 2002) and brought together, it is claimed, what had previously been a disparate body of work, using different methods, but with the shared intent of developing patient care and nursing practice (McCormack, Manley & Titchen 2013, pp. 3-4).

mental health nursing model of care, however, is not enough. While the model generated in this study may have applicability and benefit in contemporary mental health nursing practice, its application requires recognition of its relevance to service delivery and a determination to actively meet reform agenda. It is acknowledged that successful coordination of services that meets the needs of all levels of operation can be complex. Achieving support from the bottom up and top down in organisations is challenging. While commitment from professionals delivering the care is crucial, implementing practice change in organisations also depends, to a large extent, on the engagement with and understanding of the shared goals across all levels of service delivery by those who have the authority to influence decisions on policy and operational procedure, that is, the identified leaders.

## **7.4 Implications for mental health nursing leadership and management**

Integrating theoretical knowledge into practice provides a challenge for leadership in mental health nursing. This study, with its focus on recovery-based care, and other work with a similar agenda, address and are in sync with contemporary issues in mental health service delivery and reform. Application of the substantive theory in this study into practice requires more than merely providing the model.

Dissemination of this research study's findings, and its relevance to the reform agenda, can achieve greater reach across the mental health arena. However, it needs to be executed in ways that enhance understanding of the essence of the mental health nurses' contribution to positive client outcomes, thereby making it an attractive option for leaders and managers to consider in an environment of competing priorities. Exploitation of this opportunity requires trusted, authentic and self-aware leadership marked by willingness, enterprise and action by nursing leaders and managers who are in positions of influence in relation to the professional development of mental health nursing and its supply in the health workforce. As one example, an appreciation by organisations and its leaders that the specialist application of mental health nursing involves making meaning of mental tasks, as expounded in section 5.6.1 in this thesis, is crucial. Such recognition acknowledges that these essentially nursing aspects of care are therapeutic, specific to a nursing

orientation, and therefore able to be executed by this discipline in a more meaningful and productive way rather than relegating these activities to personnel without this specialist qualification and experience. By implication, this potentially enhances the quality of service provided to clients.

However, the episodic and sometimes long-term nature of mental illness may lead service providers to default to traditional ways of working. Proactive leadership, though, will be marked by open displays of appropriate knowledge and expertise, a willingness to share ideas and skills, while simultaneously understanding own strengths and limits. A commitment to engage in continuous learning and development is also needed.

Good examples of adopting theoretical constructs into practice is the application, by insightful and motivated leaders, of Barker's Tidal Model of mental health recovery and reclamation in a diverse range of practice settings (Barker & Buchanan-Barker 2010; Henderson 2013; Hoefer 2009; Jacob, Holmes & Buus 2008; Young 2010).

## **7.5 Implications for mental health nursing education**

In setting the context in which this study occurred, the issue of the specialist nature of mental health nursing practice was addressed in Chapter 2 and this study set out to explicate the distinct aspects of that practice. Therefore, its relevance for mental health nursing education is in the realm of specialist education beyond the generic nursing qualification. Reference was made to an established strategy to implement minimum requirements in under-graduate curricula to address mental health issues for nursing. However, there is no such minimum requirement for post-graduate mental health nursing curricula.

As the discipline of mental health nursing meets the challenge for consistent and coherent post-graduate curricula that reflects contemporary practice, theoretical constructs and conceptual models of care will be crucial. For example, inculcating recovery-focused mental health nursing practice, as explained in the substantive theory of this study, into post-graduate curricula would provide a theoretical concept distinct to mental health nursing and derived from practice, while augmenting the existing work of others in this area (Byrne et al. 2013; Cleary et al. 2013; Cleary, Walter & Hungerford 2014; Gale & Marshall-Lucette 2012; McLoughlin et al. 2013).

Guidance from the 'participant partnering' and 'phenomenological' attributes of mental health nursing may also be useful here. Similarly, acknowledging the 'personal' and 'psychotherapeutic' attributes of mental health nursing may encourage the incorporation of the notion of 'therapeutic intimacy' and how this can be professionally applied through specific education and training in counselling and psychotherapeutic modalities, coupled with concerted programs to identify and enhance self-awareness and emotional sensitivity.

This study has contributed to this pool of knowledge in a way that reflects contemporary practice and can be a springboard to advance and progress post-graduate curricula for mental health nursing programs. Similarly, aspects of the theoretical construct outlined in the thesis could be applied to undergraduate curricula, acknowledging the prevalence of mental health issues across all fields of healthcare. In particular, sensitivity to 'being present' with clients with mental health issues and concepts of 'co-construction' that reinforce the notion of client and recovery- focused care could potentially enhance understanding and therapeutic response to a broad range of mental health issues confronted across a diversity of nursing practice. That is, the knowledge required for specialist practice in mental health nursing has generic elements that can be translated and applied to situations outside of this specialist field in order to improve care and outcomes more broadly.

## **7.6 Implications for further research**

Any or all of the hypotheses formulated in this study are subject to further research using various methodologies. Some specific areas that may add value to the knowledge about mental health nursing as a distinct contributor to care delivery are as follows.

As previously discussed, there is potential for the substantive theory of recovery-focused mental health nursing to find its application in a diverse range of practice settings. Research projects designed to explore the impact of this model on positive client outcomes in various practice settings would add another dimension to the distinct contribution made by mental health nurses.

There is a clear need to know more in relation to when clinical care and service delivery falters, there is conflict between the consumer and the nurse, there is

communication breakdown or if the most appropriate course of action is seemingly impossible. What does this mean for the nature, scope and consequence of mental health nursing? Further to this, research exploring, in depth, the perceptions and perspectives of others, for example family members, on mental health nursing practice may elicit areas of insight unable to be examined fully in this research.

Each or any combination of the ten attributes of recovery-focused mental health nursing, or indeed the core concepts in the substantive theory, could lend themselves to further research in a context that explored their specific contribution to mental health care delivery. However, it must be acknowledged that, for this study, each of these elements is not viewed as independent, but rather interdependent and integrated to form a wholesome concept of care.

## **7.7 The impact of this study on mental health nursing identity**

One of the drivers to pursue this study was the enduring debate about mental health nursing identity. Peppered throughout the text in this thesis are references to this issue. It explores professional identity as an aspiration towards due recognition of its contribution as well as its impact on practice and the struggle by the discipline to expound its identity in a clear and assertive way.

The ambition of this study was to develop a theoretical model of nursing, generated from practice by mental health nurses, that is authoritative in terms of legitimatising the discipline's identity and scope of practice within a distinct nursing paradigm that facilitates an understanding of it by others.

Embedded in the substantive theory generated by this study is an explanation of the distinct nature and identity that is mental health nursing. It drives practice in a peculiar way that is based on an interaction with clients that is both special and productive in terms of positive consequences for the aspirational outcomes of both the clients and the nurse. The relationship formed by nurses with clients is an interdependent and interactive interplay and is the result of the nature of the discipline itself and its work. In the analysis of participant data, the attributes of mental health nursing described provide constant reference to the acts of mental health nurses that portray their distinct contribution to fruitful care. The feedback

from participants in this study provided affirmation about the veracity of these attributes in relation to their personal professional experience. It provides an opportunity, therefore, for other mental health nurses to identify with these attributes, critique them in terms of their own practice and/or adopt them to enhance their practice. Most of all, it not only allows mental health nurses to deepen their understanding of their practice, but also to articulate clearly its distinguishing features, and the esteem that comes with it, to others.

## **7.8 Personal reflections**

It is only at the penultimate point of this study, before my final concluding remarks, that I can give a genuine personal account of the experience in undertaking this work. I can honestly say that the journey has been a stimulating and enjoyable one of discovery at a number of levels.

Firstly was the realisation of the responsibility and accountability of embarking on work at this level of expected academic achievement. This did not induce anxiety about my ability to achieve the outcome, but rather excited my ambition to reach it. This level of confidence came from a working lifetime of positions of responsibility and accountability, the familiarity with which was an asset. It did instil, though, a firm commitment to undertake the task with due diligence, knowing that previous professional and academic achievements would stand me in good stead.

Secondly, the decision to pursue this degree came at a time when I had no other conflicting encumbrances either personally or professionally. I had no full time job, my children had long since left home, I was financially secure and I wanted to remain professionally engaged in order to continue to contribute my knowledge, skills and experience. This sense of freedom provided the head space and energy to consider research as a serious medium by which to plan my future professional involvement.

Thirdly, I have always identified strongly with mental health nursing as a fulfilling and worthwhile career and valued it for its enhancement of my own personal values and beliefs. I therefore wanted to find expression for it, not just for me, but for other mental health nurses past, present and future. Not surprising, then, is the question driving this study; what's special about mental health nursing? I had to constantly struggle to hold on to the question throughout the research in order to keep the



'general wonderment' about the phenomena I was exploring. This did not serve as a personal frustration but rather enhanced the excitement of maintaining the mystery, an inherently satisfying aspect of grounded theory method in my opinion.

As I listened to mental health nurses recounting their work and articulating the way in which they saw and related with their clients, it reinforced my admiration for those nurses who modestly and humbly execute their skills with such competence and commitment, often not understood or appreciated for its gravity. I was searching for the 'special' in the 'specialist' and constantly felt the responsibility of doing it justice. In the end, of course, it is they who did it justice while I have the privilege of telling it like it is. I trust I have served them well.

The process and result have been a positive experience for me. My own identity as a mental health nurse has been buoyed by it and I hope dissemination of the work has a similar affect for my colleagues.

## **7.9 Conclusion**

This research study, as originally conceived, had the title "Outcomes of mental health nursing interventions: A nursing model of care". It proposed that a grounded theory approach would be adopted to develop a concept model of mental health nursing practice and its impact on client outcomes. It proposed that it would go beyond my previous research at Masters level which, again using a grounded theory approach, studied a mental health nursing perspective of expected outcomes of care for persons with enduring mental illness. It intended to focus on a nursing cohort who delivers its care in an autonomous way, in order to maximise the opportunity to study interventions that are significantly, if not solely, nurse delivered. It also envisaged that determination of client outcomes would be by quantitative measures, where used, and qualitative reports of evidence of care progress as reported by the nurse delivering the care, and reports of progress by the clients if possible. The expected outcome for the study was the development of a model of care that would provide the mental health nursing discipline potential guidelines for practice as well identify areas for further exploration and research in order to advance quality, effective and client-focused care.

This embryonic proposal served the purpose of providing a somewhat coherent application for candidature in a PhD program, however, it bore very little resemblance to the phenomena that would be emphasised in the final product. It did, though, provide the impetus to de-construct this proposal in order to filter out the issues that were of more significant interest and concern for me in pursuing this level of research. It is not clear to me now at what point a transition in my thinking took place toward a more relevant study question, but it was consolidated by the time I submitted my research plan some five months after enrolment as a PhD candidate.

The question 'what's special about mental health nursing' has persisted throughout the study and has been the impetus for every aspect of this inquiry. It had enough breadth to open the inquiry as widely as it needed to be, while at the same time, posed a specific challenge to examine the essence of mental health nursing that distinguished it as a distinct discipline of the profession of nursing. Neither of these aspects always sat comfortably with me as the researcher. Its breadth threatened to open too many avenues to explore in one piece of work while its specificity implied that there was one definitive answer. When first presenting and posing the question to my colleagues, I sensed they embraced the idea of this pursuit as one that would finally provide a definitive and all embracing explanation of mental health nursing with which they could identify. This seemed to be a huge responsibility to carry for the discipline and one I doubted I had the capacity to meet. This anxiety was, of course, naïve on my part and reflective of limited research experience. Nevertheless, ongoing anxiety promotes reflection and review and served to keep the process of inquiry an active one. Indeed, the question posed remains in the title of the thesis as a legacy to its crucial role in shaping the ultimate dissertation.

While essential, self-reflection was not the only means of gaining significant insights about the inquiry and its process along the way. It is difficult to realise your own limitations in thinking and conceptualising without feedback from external sources. In fact, a number of important concepts developed in this study were spawned from observations, ideas, suggestions and critical appraisal from others. The initial defensiveness this, at times, induced provided the motivation to envisage a fresh perspective of the work in which I was engaged and sometimes engulfed. For example, I was frequently asked what this study was about. Discussing this with mental health nurse colleagues tended not to arouse any contentious issues.

However, providing an explanation of the inquiry to a psychiatrist colleague resulted in a very different response. I was quizzed vigorously about how I could possibly provide an explanation of what is special or distinctive about a mental health nurse's contribution to positive client outcomes without comparative analysis with other disciplines providing this care. My attempts to clarify that this was an introspective process using qualitative methodologies to explicate the essence of mental health nursing irrespective of other ideologies provided no assurances. I could have dismissed the event as one person not understanding forms of inquiry outside of a positivist frame, however the question challenged my own understanding about what I was attempting. I could not ignore the fact that if one person did not understand the purpose and benefit of the study, perhaps there was a problem in its expression.

This, and other instances of external feedback and comment, provided a turning point in this inquiry in order to ensure that it rang true to its aims. I wanted the process to be transparent and understood by whoever came across it. I also wanted a mechanism by which I could make sense of memos, lend another level of conceptual thinking about the interpretations of data and communicate my hunches and developing ideas in a concise way and which stimulated external critique. This mind space generated the introduction of Progress Bulletins. It also motivated me to submit abstracts to local, national and international conferences to provide a deadline to disseminate the research study's progress and emerging ideas. A scan of the titles of presentations in Appendix 13 demonstrates this. I also made a commitment to submit manuscripts to refereed journals. I submitted one article to a journal but it was promptly dismissed as unsuitable. I made some other attempts to achieve this goal. Regrettably, however, my lack of experience in publishing scholarly articles defeated me, a skill yet to be honed.

My choice of a qualitative study was the right one for this inquiry. I have no grounding or talent for quantitative statistical analyses. Nor did I want to subject this study, which aspired to providing an explanation of mental health nursing from the perspective of those practising it, to objective and sterile examination. My first hunch that a grounded theory methodology was suited for it was borne out by its application. It drove me to think beyond description and, executed within a constructivist paradigm, suited my pre-disposition towards a relativist and subjectivist approach to the inquiry. Coming to a position of confidence with this approach took

longer that I had anticipated but I was determined to undertake the analysis of data with a clear method and a philosophy to match. Again, testing out my understanding of the methodology and methods in front of an audience at conference presentations and through conversations with colleagues facilitated increasing familiarity and expertise in their application.

I am confident that I have exhausted the data used in this research for their raw material to make the interpretations and formulate the concepts expressed in this thesis that are grounded in that data. I am also encouraged by the positive affirmation of these conceptualisations given by the participants in the study.

I had no idea when beginning this research study that the question 'what's special about mental health nursing' would reveal that 'being in the here and now, side by side, co-constructing care' represented a substantive theory of 'recovery-focused mental health nursing'. Such is a true journey of discovery, initially shrouded by mystery and speculation, progressively revealing itself through the voice of the study's informants. The theory was a construction by me, from interpretations of stories from my participants about their lived experience in the realm of mental health care. Their expressions of these accounts came from their own construct of a world in which their part was motivated towards better mental health outcomes. The coalescence of their and my constructions was the basis of conceptual ideas that generated the substantive theory presented in this thesis. The notion of co-construction provided the paradigmatic approach to this study, strongly supported by a philosophy of symbolic interactionism. Meanings were made of the interactions experienced by participants in their encounters with and within the mental health arena, enhanced by their encounter and interaction with me as a researcher. It will be interesting to see how the discipline of mental health nursing, the nursing profession generally, consumers of mental health services and other professional disciplines, interested in and contributing to aspirations for improved mental health, interpret and construct this body of work as they encounter it.

An original piece of work can drive a researcher, once engaged, to continue inquiry on varying trajectories that emanate from it. At some point however, a line needs to be drawn under one piece of work in order to provide the freedom and space to explore other avenues of inquiry. Therefore, I now draw a line under this body of

work to facilitate this future and ongoing process. Pursuing this work has inspired me and I would like to think that it inspires others to continue to explore this, or any related phenomena, that have, as their aim, to improve and enhance the lives of those for whom we care.

## References

**PLEASE NOTE:** *The referencing style used in this thesis is the "Harvard 2002 UTAS" version. Some references are not preceded with the author name but with a line only. This denotes that the author name/s is the same as the previous reference author name/s and is an acceptable form for this reference style.*

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## **Appendix 1: Master of Nursing Grounded Theory Research Thesis, P. Santangelo: Psycho-Social Process and Nursing Model Generated**

The core variable emerging from the data in this study can be named the “nursing care health improvement spiral”. This model of care is outlined in Figure 9 and attempts to represent the following characteristics:

1. The process of nursing care is a continuum from a state of ill health, or altered health status, to health. In the case of serious mental illness, where cure is not common, health will often mean amelioration of symptoms of illness and adaptation to an altered health status;
2. This continuum of health improvement is over a time scale. Because serious mental illnesses are complex and diverse in presentation, and induce various levels of disability, the time scale is variable and may be a long process of care. The greater the disability, the longer the process of care;
3. This process of care is aimed at helping to shift clients from a state of dependence (on treatment) to a state of independence (adaptation);
4. Simultaneously, the level of nursing care along this continuum moves from intensive and restrictive care to minimal intervention as empowerment of the client grows;
5. The progression towards independence, adaptation and health is a spiral, with each event of care and intervention producing a positive outcome which stimulates an advancing progression toward health. That is, a synthesis of positive health gains or outcomes towards an optimum level of health and independence.

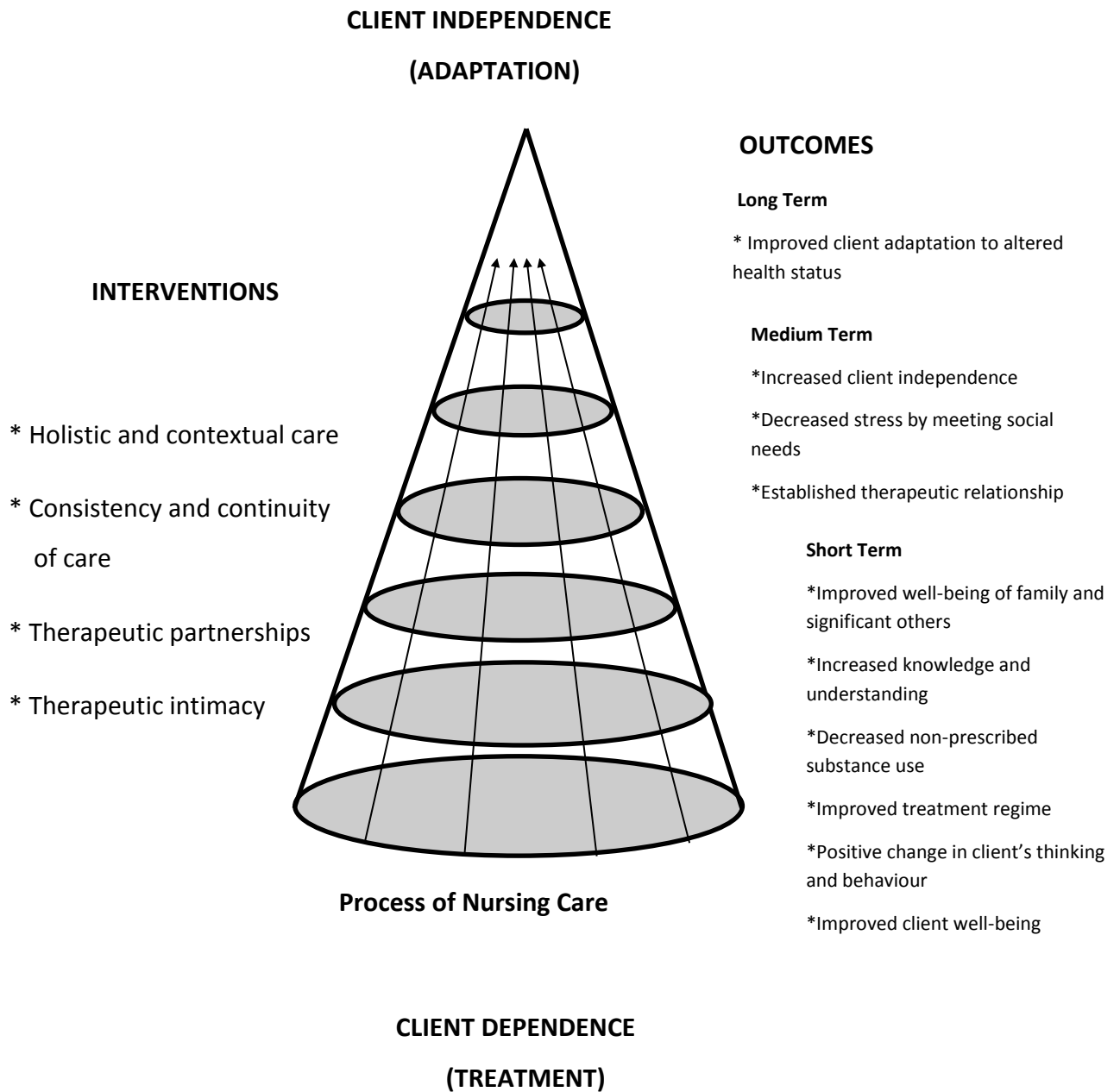
From the hypotheses pertaining to nursing care developed in this study, a theory of nursing practice emerges which purports that nursing has distinctive knowledge and practice. This distinctive knowledge and practice provide a perspective to care that impact in a way that results in positive client outcomes. More specifically for mental health nurses in the context of this study, the theory statement would be expressed in two parts, namely:

1. Mental health nursing relies on a humanistic, holistic model of practice for health improvement that utilises the therapeutic relationship as the foundation for all its interventions; and
2. The development of expertise in this practice area is experienced based and enhanced through working with seriously mentally ill clients in settings where autonomy in practice occurs.

## Appendix 1 continued

**Figure 9: The Nursing Care Health Improvement Spiral**

The process of nursing care, utilising nursing therapeutics, is a cycle that progressively achieves positive outcomes, over a time span, increasingly towards client adaptation and independence.



## Appendix 2 –Guidelines for self-evaluation of grounded theory

Criteria for self-evaluation of this research study based on the work of Beck, Cooney, Chiovitti & Pira, Charmaz and Birks & Mills

DOMAIN	CRITERIA
<b>Researcher expertise</b>	<ul style="list-style-type: none"> <li>• The researcher demonstrates skills in scholarly writing</li> <li>• There is evidence that the researcher is familiar with grounded theory methods</li> </ul>
<b>Methodological fit for purpose</b>	<ul style="list-style-type: none"> <li>• There is a clear description of how the grounded theory methodology was applied.</li> <li>• The researcher has articulated their philosophical position in relation to the chosen methodology.</li> </ul>
<b>Design and method</b>	<ul style="list-style-type: none"> <li>• There is a rationale for and description of the research design, process, data collection and analysis including the generation of theory.</li> <li>• Contextual data, such as demographic information on the sample, and the study setting characteristics has been provided and is sufficient to enable the reader to understand the study context.</li> <li>• The description of the sample is clear and provides enough information to allow the reader to judge if the sample is sufficiently diverse to reflect the complexity of the situation or problem.</li> </ul>
<b>Data management</b>	<ul style="list-style-type: none"> <li>• An audit trail, including memos, has been provided detailing the researchers' personal beliefs, values and assumptions.</li> <li>• Ethical considerations are explicit and justified.</li> </ul>
<b>Data analysis process</b>	<ul style="list-style-type: none"> <li>• Emerging codes were confirmed with participants in later interviews.</li> <li>• Participants' concepts were used to develop new questions.</li> <li>• Systematic comparisons between observations and categories are made.</li> <li>• Categories cover a wide range of empirical observations.</li> <li>• Gaps between categories are identified.</li> <li>• Theoretical sampling is used to elaborate meanings of categories.</li> <li>• There are strong logical links between the gathered data and the argument and analysis.</li> <li>• Feedback from participants or experts giving their opinion of the theory has been included.</li> </ul>

## Appendix 2 continued

DOMAIN	CRITERIA
<b>Data authenticity</b>	<ul style="list-style-type: none"> <li>• Excerpts from the data have been used to support the findings.</li> <li>• Categories portray the fullness of the studied experience</li> <li>• Data range, number, and depth of observations contained in the data are sufficient to merit the claims made to allow the reader to form an independent assessment and agree with the claims.</li> </ul>
<b>Research outcomes</b>	<ul style="list-style-type: none"> <li>• The research has achieved intimate familiarity with the phenomenon of interest in the context in which it occurs.</li> </ul>
<b>Originality</b>	<ul style="list-style-type: none"> <li>• Categories are fresh and offer new insights.</li> <li>• The analysis provides a new conceptual rendering of the data.</li> </ul>
<b>Transferability</b>	<ul style="list-style-type: none"> <li>• Analytic categories include nuances and underlying meanings and suggest some generic processes.</li> <li>• The analysis offers interpretations that people can use in their everyday worlds</li> <li>• The grounded theory generated makes sense to the participants or people who share their circumstances and offers them deeper insights about their lives and worlds?</li> </ul>
<b>Usefulness</b>	<ul style="list-style-type: none"> <li>• The study has social and theoretical significance.</li> <li>• The grounded theory generated challenges, and extends, and/or refines current ideas concepts, and practices.</li> <li>• The analysis can spark further research in other substantive areas.</li> <li>• The study contributes to knowledge and making a better world.</li> </ul>

### Beck's 2009 criteria for critiquing qualitative research (Beck, C 2009, p. 544)

<b>Credibility</b>	Refers to the believability of the data and the confidence one has in the truth of the findings.
<b>Dependability</b>	Focuses on the stability of the data over time and in different contexts and conditions.
<b>Confirmability</b>	Deals with objectivity, which is viewed as an agreement between two or more people reviewing the findings for accuracy and meaning.
<b>Transferability</b>	Refers to the ability of the findings to be transferred to other contexts (eg, do the results have applicability to other groups?).
<b>Authenticity</b>	Focuses on the degree to which researchers faithfully and fairly described participants' experiences.

## Appendix 2 continued

Enhancing standards of rigour: Suggested and methods of research practice using Beck's 1993 criteria (Beck, CT 1993)

DOMAIN	COONEY'S CRITERIA (Cooney 2011, pp. 20-21)	CHIOVITTI & PIRAN'S METHODS OF RESEARCH (Chiovitti, R & Piran 2003, p. 430)
<b>Credibility</b> (believability of the data)	<ul style="list-style-type: none"> <li>• Has a clear description of how the grounded theory methodology was applied been provided?</li> <li>• Is there evidence that emerging codes were confirmed with participants in later interviews?</li> <li>• Is there evidence that participants' concepts were used to develop new questions?</li> <li>• Have excerpts from the data been used to support the findings?</li> <li>• Has feedback from participants or experts giving their opinion of the theory been included? Feedback should indicate if the theory made sense, 'paints a picture of their world', is vivid, explains their situation and is useful. The latter criterion is more appropriate for expert reviewers.</li> </ul>	<ol style="list-style-type: none"> <li>1. Let participants guide the inquiry process.</li> <li>2. Check the theoretical construction generated against participants' meanings of the phenomenon.</li> <li>3. Use participants' actual words in the theory.</li> <li>4. Articulate the researcher's personal views and insights about the phenomenon explored by means of:               <ol style="list-style-type: none"> <li>(a) Post-comment interview sheets used as a tool;</li> <li>(b) A personal journal;</li> <li>(c) Monitoring how the literature was used.</li> </ol> </li> </ol>
<b>Auditability</b> (maintaining a comprehensive record of all methodological decisions)	<ul style="list-style-type: none"> <li>• Has an audit trail in the form of memos been provided that details the researchers' personal beliefs, values and assumptions?</li> <li>• Rationale for the research design, including a description of the research process, data collection process and sampling decisions?</li> <li>• Approach to analysis and generating theory?</li> <li>• With regards to the latter point, Chiovitti and Piran (2003) recommended that researchers should give examples of the questions used to interrogate the data, and record and trace relationships as they emerge (Figure 1).</li> </ul>	<ol style="list-style-type: none"> <li>5. Specify the criteria built into the researcher's thinking.</li> <li>6. Specify how and why participants in the study were selected.</li> </ol>

## Appendix 2 continued

DOMAIN	COONEY'S CRITERIA	CHIOVITTI & PIRAN'S METHODS OF RESEARCH
<b>Fittingness</b> (or 'transferability' which is concerned with demonstrating that the findings have meaning to others in similar situations)	<ul style="list-style-type: none"> <li>Has contextual data, such as demographic information on the sample, study setting characteristics, the philosophy of care and/or other relevant local policy, been provided that is sufficient to enable the reader to understand the study context?</li> <li>Is there a clear description of the sample, such as who was included, how and why?</li> <li>The aim is to provide enough information to allow the reader to judge if the sample is sufficiently diverse to reflect the complexity of the situation or problem.</li> </ul>	7. Delineate the scope of the research in terms of the sample, setting, and the level of the theory generated. 8. Describe how the literature relates to each category which emerged in the theory.

### Charmaz's criteria for evaluating grounded theory studies across four domains (Charmaz 2006, pp. 182-183)

DOMAIN	CRITERIA
<b>Credibility</b>	<ul style="list-style-type: none"> <li>Has your research achieved intimate familiarity with the setting or topic?</li> <li>Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data.</li> <li>Have you made systematic comparisons between observations and between categories?</li> <li>Do the categories cover a wide range of empirical observations?</li> <li>Are there strong logical links between the gathered data and your argument and analysis?</li> <li>Has your research provided enough evidence for your claims to allow the reader to form an independent assessment – and agree with your claims?</li> </ul>
<b>Originality</b>	<ul style="list-style-type: none"> <li>Are your categories fresh? Do they offer new insights?</li> <li>Does your analysis provide a new conceptual rendering of the data?</li> <li>What is this the social and theoretical significance this work?</li> <li>How does your grounded theory challenge extend, or refine current ideas concepts, and practices?</li> </ul>
<b>Resonance</b>	<ul style="list-style-type: none"> <li>Do the categories portray the fullness of the studied experience?</li> <li>Have you revealed both liminal and unstable taken-for-granted meanings?</li> <li>Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate?</li> <li>Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?</li> </ul>



## Appendix 2 continued

DOMAIN	CRITERIA
<b>Usefulness</b>	<ul style="list-style-type: none"> <li>• Does your analysis offer interpretations that people can use in their everyday worlds?</li> <li>• Do your analytic categories suggest any generic processes?</li> <li>• If so, have you examined these generic processes for tacit implications?</li> <li>• Can the analysis spark further research in other substantive areas?</li> <li>• How does your work contribute to knowledge? How does it contribute to making a better world?</li> </ul>

**Birks and Mills' criteria for evaluating grounded theory research** (included as Table 9.2 in Birks & Mills 2011, pp. 153-154)

DOMAIN	CRITERIA
<b>Researcher expertise</b>	<ul style="list-style-type: none"> <li>• Does the researcher demonstrate skills in scholarly writing?</li> <li>• Is there evidence that the researcher is familiar with grounded theory methods?</li> <li>• Has the researcher accessed and presented citations of relevant methodological resources?</li> <li>• Are limitations in the study design and research process acknowledged and addressed wherever possible?</li> </ul>
<b>Methodological congruence</b>	<ul style="list-style-type: none"> <li>• Has the researcher articulated their philosophical position?</li> <li>• Is grounded theory an appropriate research strategy for the stated aims of the study?</li> <li>• Do the outcomes of the research achieve the stated aims?</li> <li>• Is a grounded theory presented as the end product of the research?</li> <li>• Are philosophical and methodological inconsistencies identified and addressed?</li> </ul>
<b>Procedural precision</b>	<ul style="list-style-type: none"> <li>• Is there evidence that the researcher has employed memoing in support of the study?</li> <li>• Has the researcher indicated the mechanisms by which an audit trail was maintained?</li> <li>• Are procedures described for the management of data and resources?</li> <li>• Is there evidence that the researcher has applied the essential grounded theory methods appropriately in the context of the study described?</li> <li>• Does the researcher make logical connections between the data and abstractions?</li> <li>• Is there evidence that the theory is grounded in the data?</li> <li>• Is the final theory credible?</li> <li>• Are potential applications examined and explored?</li> </ul>

## Appendix 3: Progress Bulletins 2-6



School of  
Nursing & Midwifery

Bulletin No 2, 23 Aug 2012

### What's Special about Mental Health Nursing? A Grounded Theory study

## What's happening?

#### Progress to date

It has taken just over three months but here we have the second bulletin mapping the progress of this research.

Since I wrote to you in May, I have been busy interviewing mental health nurses (MHNs) from a pool of over 120 potential participants. I have been very pleased with this response as it affirms for me that the study question resonates with mental health nurses in contemporary practice.

I have conducted 25 interviews involving 28 MHNs (one was a focus group of 4). I am now going through transcripts of interviews as part of initial comparative data analysis.

#### Purpose of the bulletins

You may recall that these progress bulletins will serve as information to you about how the research is going, but also to provide a quality cross-check on the relevance and accuracy of issues emerging as well as giving you the opportunity to comment,

criticise and/or add your own ideas to what is emerging from the data collected. Some of the issues will be quite raw however I am keen to maintain your input as part of the process of discovery.

#### A teaser!

A number of MHNs I have interviewed so far have indicated that the 'experience' of nursing, and mental health nursing, has laid foundations for future practice and enhanced learning toward practice that is both effective in terms of outcome and distinctive to MHNing.

For example, many referred to the experience of working in acute settings, and often very early in their career. They describe, as vulnerable young people, being exposed to extremely disturbed environments where, as nurses, they had to confront and manage, unlike other disciplines whose contact with this environment was sporadic and short-lived knowing there were nurses to provide the ongoing management. This experience has engendered a distinct capacity to tolerate challenging behaviours and

situations from which specific skills have developed. These include:

- being able to 'be' with people irrespective of their presentation, an important engagement skill as it conveys acceptance and caring;
- understanding the complexity of issues that confront and confound clients, communicated from the perspective of the client;
- the need and ability to draw on a broad range of strategies in order to assist the client to attain their goals, on their terms.

These are some broad-brush descriptions and interpretations from the data that have rung true for some people.

Do these issues resonate for you and your practice?

Do you have examples of how the 'experience' as a nurse make what you do special?

I would like to hear of any thoughts you have about this. Of course, in accordance with the ethics of this research, all responses are confidential.

*"Like Grounded Theory, the nursing process involves a constant comparison of collected data, hypothesis generation, use of the literature as data, and collection of additional data to verify or reject hypotheses".*

(Stern et al, 1984)

**Regular bulletins will keep you updated with the progress of this research study.**

**For further information, contact the researcher:**

Peter Santangelo on 0438 479392 or by email at:  
[psantangelo@bigpond.com](mailto:psantangelo@bigpond.com)

**Chief investigators:** Professors Nicholas Procter and Denise Fassett

# What's Special about Mental Health Nursing? A Grounded Theory study

## Do MHN's relate differently?

### Nursing interactions

In my last bulletin, I alluded to mental health nurses being able to 'be' with people, an engagement skill that conveyed acceptance and caring irrespective of how disturbed or challenging the presentation.

Mental health nurses described this interaction as one that is very much on the client's level, an attempt to equalise the power in the relationship. They also told me that clients acknowledge this style of engagement, saying that they can talk to the mental health nurse about anything because the interaction is not stilted by an 'objective' (my word, not theirs) professional manner. This is also confirmed by clients I have interviewed.

Halter (2002, p.25) proposes that mental health nursing, as a profession, is stigmatised in the same way as mental illness and persons with mental illness are stigmatised by society, which she refers to as 'stigma by association'. She infers that this is related to their integral advocacy role for persons

who are victims of mental illness and societal misconceptions. She considered that this has the propensity to retard the growth of the profession and in order to re-vitalise the profession, she purports that *"the development of a knowledge base that more fully describes and supports the art of psychiatric nursing, including the nature of therapeutic relationships, is necessary"*. (2008, pp. 26-27).

### A proposition

Is it fair to assume that traditionally, mental health nurses do not enjoy the same level of status as their medical and allied health colleagues?

Can it also be assumed that this influences mental health nurses to identify closely with their clients' needs and situations as they are 'in the same, or similar boat' so to speak?

Does this 'forced' social status and place of mental health nursing therefore work in favour of the client by engendering enhanced equality in the relationship?

Nurses I have spoken to account for

this by their experience, often in hospital settings, of spending lengthy times with clients talking about ordinary issues often in the process of delivering nursing care or ascertaining what issues are important for the client.

They also relate that this manner of engagement is closely linked to their value of client centredness, and in particular, being guided by the client's perception and stated needs rather than conveying that they, the nurse, knows what is best for them, the client.

What do you know from your own experience, practice and self-reflection?

As a mental health nurse, is your relationship with clients different from how other disciplines relate to clients?

Is there something about the nursing experience that provides a distinct contribution to positive and therapeutic interactions with clients?

Your thoughts about this are very welcome and of course kept in confidence.

Halter, MJ 2008,  
'Perceived Characteristics  
of Psychiatric Nurses:  
Stigma by Association',  
*Archives of Psychiatric  
Nursing*, vol. 22, no. 1, pp.  
20-26.

**Regular bulletins will keep you updated with the  
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## Appendix 3 continued



Bulletin No 4, 14 Sept 2012

# What's Special about Mental Health Nursing? A Grounded Theory study

## *Research methodology mirroring practice?*

### Practice observed

For those of you who have already participated directly in this research study, you will know that I am curious about what interventions that you, as a mental health nurse, use to affect a positive outcome for your clients. In particular, I inquire about those interventions that may be distinctive to mental health nursing practice.

Nurses have reported to me that they use a broad sweep of interventions, skills and techniques learnt over time. They range from evidence-based interventions and psychotherapeutic paradigms to other acquired skills and interventions based on things that have worked over time but may not have a specific therapeutic label.

Whatever intervention/s is/are used most often, the primary reason for their choice is what fits best with what the client needs and is prepared to engage in.

So while so called 'evidence based' interventions are valued, mental health nurses do not restrict themselves to using these alone, confident that other inter-

ventions are both required and effective in ensuring a positive client outcome.

The issue of priority is facilitating an outcome generated by the client. The mental health nurses I have interviewed differentiate themselves from other disciplines because of this broad orientation and focus of their practice.

They describe that their practice is driven by establishing a firm and trusting relationship with their client which facilitates the generation of ideas and actions that move towards the implementation of strategies for the outcome the client wants. In this way, the intervention therefore is not prescribed by an external set of rules or paradigms, but by the process of interaction catered specifically for that client.

Further, the intervention designed to afford a positive outcome is a product of the cooperation and interaction of the mental health nurse and the client working in concert—a distinct experience each time and not always predictable in advance in terms of outcome, unlike prescribed interventions which can have a rigid pathway to expected outcomes.

### Research methodology in this study

The research I am pursuing is qualitative research with its aim to generate a theoretical model of mental health nursing practice. Specifically, it is Grounded Theory using a constructivist philosophy.

This, in simple terms, proposes that theory generation is not 'discovered' in the data, but rather is a co-construction between researcher and participants where the voice and meaning of the participants' contribution is emphasised.

I am proposing that there is a synchronicity between the methodology used and the practice described in the data. That is, the distinctive aspect of mental health nursing practice, in achieving positive outcomes for their clients, is embedded in the practice of co-constructing the therapeutic strategies and interventions rather than follow a pre-defined script.

Again, your thoughts about this are very welcome and as always, kept in confidence.

*"... people, including researchers, construct the reality in which they participate."*

(Charmaz, K 2006, *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*, Sage Publications Ltd, London, page 187)

***Regular bulletins will keep you updated with the progress of this research study.***

***For further information, contact the researcher:***

Peter Santangelo on 0438 479392 or by email at:  
[psantangelo@bigpond.com](mailto:psantangelo@bigpond.com)

***Chief investigators:*** Professors Nicholas Procter and Denise Fassett



## Appendix 3 continued



School of  
Nursing & Midwifery

Bulletin No 5, 9 Oct 2012

# What's Special about Mental Health Nursing? A Grounded Theory study

## *Time and flexibility— a special facility!*

### What matters to clients?

To date, I have interviewed five clients of mental health nurses (MHN). I have already mentioned in my previous Bulletin that clients confirm that their engagement with MHNs are different from that with other disciplines. They feel the MHN relates at their level and that they are an equal partner in the therapeutic relationship.

They also talk about two other elements that are important in their contact with the MHN—time and flexibility.

For the clients I interviewed, the 'time' element has three advantageous aspects.

Firstly is the amount of time a MHN is prepared to give, far more generous than they experience with other healthcare professionals. Secondly is the frequency and consistency they are with the MHN—perhaps no so distinct but again the amount of time given is determined by the client's need at that time. And thirdly, time that is made available outside of scheduled sessions should the client need support.

The other element, 'flexibility', also has several aspects. Of particular note is the flexibility to be seen at home. This has become a rare commodity with health care delivery and is appreciated when transport, home-bound commitments or social anxiety is a factor. So for some, it is an unexpected facility, it's special. And it is cherished for its display of respect for and acceptance of them, on their own territory.

'Flexibility' in how the service is delivered is also valued. Other than home visits and centre-based appointments, sessions can take place anywhere. The deciding factor is what facilitates the best outcome. For example a visit to Centrelink or the Housing Department with the MHN for purposes of providing support, advocacy and/or provider networking is not uncommon. Similarly, a walk on the beach, a coffee at a local café with the MHN or the MHN participating directly in an activity being encouraged for the client also occurs as it is required. An example of the latter is one MHN who reported going swimming with a client who needed encouragement to engage in physical exercise.

### What matters to MHNs?

Having the opportunity and confidence to practice autonomously and to witness positive client outcomes as a result are two of the most valued aspects of the work done by MHNs I have interviewed.

Grounded\* engagement with clients, time and flexibility are media which facilitate this work satisfaction. Of significant import is the freedom to practice to the very edges of the boundaries of their profession in both traditional and creative ways—whatever works for the client. While some of the activities in which MHNs engaged are outside of the self-imposed remit of other disciplines, I stress that MHNs view their professional boundaries as maintained through these activities.

### What matters to you?

Do these issues sound familiar chords for you?

Are there other aspects of practice that also distinguish MHNing?

Please feel free to contribute — confidentiality guaranteed.

*\* Grounded—"... having a secure feeling of being in touch with reality and personal feelings" or "... based on reason, reliable evidence or good sense."*

A definition from the Macquarie International English Dictionary

**Regular bulletins will keep you updated with the progress of this research study.**

**For further information, contact the researcher:**

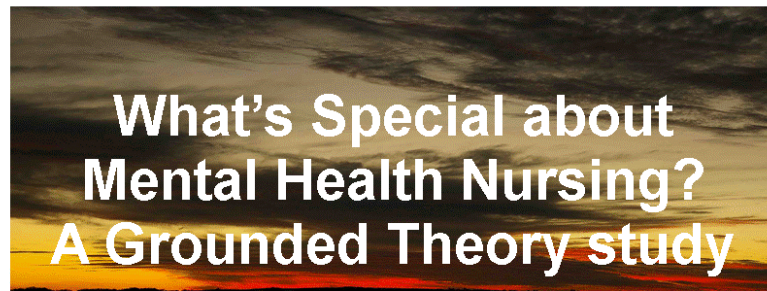
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## Appendix 3 continued



Bulletin No 6, 21 Dec 2012



### *Defining distinctive mental health nursing practice*

#### **Phenomena of interest in this study**

This study uses grounded theory techniques to explore and explicate what it is that mental health nurses do to bring about a positive outcome for people they work with.

As its primary focus, the study aims to conceptualise the essence of mental health nursing (MHNing) practice; what makes the practice special and distinctive. It seeks to identify how, when and where MHNing makes its contribution in mental health service delivery.

What the study does not do is attempt to compare MHNing with other disciplines. Rather, the aim of this study is to analyse its own inherent and idiosyncratic qualities. Below are some emerging themes arising from this work.

#### **What is distinctive about MHNing?**

MHNing, and nursing in general, has specific curricula for its education. Its knowledge base is borrowed from various other disciplines and consolidated in curricula that claims a characteristic nursing orientation and, as a composite, is different from education of other disciplines.

The nursing skill set is also articulated, in clinical practice, in different ways from other disciplines—it is a different job with peculiar practices.

In addition, nursing has a history as a developing profession that has experienced a status in both the general community and among other professions that distinguishes it as an entity in itself.

So it may seem an easy task to define MHNing as distinctive in terms of these characteristics. However, is there a remarkable or extraordinary impact on mental health care as a result? That is, whatever it is that makes MHNing happen, is it special in terms of its contribution to mental health care? And if so, how?

#### **What are MHNs saying?**

In previous Progress Bulletins, I have outlined some issues that have emerged from interviews in this study about MHNing practice.

It was reported (Bulletin No 1) that this practice yields significant positive outcomes for mental health consumers.

In subsequent Bulletins, it was reported that the peculiar experience of working as a nurse in a number of challenging settings engendered, in sustainable practice, a sensitivity to consumers that is up close and caring

and tolerant of any relational challenges presented.

Interventions are broad in their scope and driven and guided by the needs of the consumers rather than adherence to some prescribed or pre-determined therapeutic tools or techniques. In this way, the therapeutic alliance, and consequently the therapeutic outcome, is a co-construction hosted in the intersubjective therapeutic encounter between the MHN and the consumer.

Furthermore, this is executed with flexibility in terms of practice and its boundaries and with a generous devotion of time that deepens trust and facilitates better access, engagement and the overall shape of the therapeutic alliance.

In these accounts, it is reported that the 'lived experience' of nursing has been a potent influencing factor in how and why this practice is delivered.

#### **What next?**

I again welcome your comments and ideas.

With ongoing analysis of the data, I will present emerging ideas, as they develop, in future Bulletins.

Thank you for your ongoing interest and best wishes for Christmas and the New Year.

*Distinct—“clearly different and separate from others - strong enough, large enough or definite enough to be noticed.”*

*Distinctive—“uniquely characteristic of a person, group or thing”*

(Macquarie International English Dictionary)

***Regular bulletins will keep you updated with the progress of this research study.***

***For further information, contact the researcher:***

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[psantangelo@bigpond.com](mailto:psantangelo@bigpond.com)

***Chief investigators: Professors Nicholas Procter and Denise Fassett***

## Appendix 4 - Eligibility Criteria for Mental Health Nurse Participants

### **STUDY TITLE: What's Special about Mental Health Nursing? A Grounded Theory study**

The Australian College of Mental Health Nurses (ACMHN) describes a mental health nurse as a registered nurse who *"holds a recognised specialist qualification in mental health ...taking a holistic approach, guided by evidence ... works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual"*.

It further states that *"Where a nurse meets the minimum requirements, in terms of qualifications in mental health, demonstrated recent experience in the field and commitment to ongoing professional development, s/he may apply for and be awarded a Mental Health Nurse Credential by the ACMHN. In Australia, new national registration guidelines do not endorse mental health nurses. As a result, the only nationally consistent way of identifying a mental health nurse is through the ACMHN Credential for Practice Program"*. (2010, p. 5)

Consistent with the criteria for Credentialing with the ACMHN, mental health nurses eligible to participate in this study will be either:

#### **1. A Credentialed Mental Health Nurse with the ACMHN**

OR, consistent with the criteria for Credentialing (Australian College of Mental Health Nurses Inc 2010a),

#### **2. A Registered Nurse with:**

- a. **A current licence to practice** as a registered nurse in Australia;
- b. **Mental Health Nursing qualifications.** That is, completion of a specialist mental health nursing/psychiatric nursing qualification. With the cessation of hospital based pre and post-registration programs, qualifications available for specialist practice are conducted through Universities as post-graduate diplomas and degrees. You must have completed a clearly defined mental health nursing/psychiatric nursing course, undertaken in Australia as listed below:
  - i. Clinical Master degree;
  - ii. Post-Graduate Diploma;
  - iii. Direct entry into mental health nursing/psychiatric nursing undergraduate diploma or degree;
  - iv. 3 year hospital based course that led to registration as a mental health nurse;
  - v. Hospital post-registration course (12 months full-time equivalent) that led to qualifications as a specialist mental health /psychiatric nurse by the relevant nurse registration authority at the time of completion;
  - vi. Applicants with overseas qualifications with registration as a nurse by a nurses' Board or Council in Australia on the basis of a direct entry mental health nursing/psychiatric nursing qualification from another country;
  - vii. NOTE: A post-graduate certificate only is not acceptable.

## Appendix 4 continued

- c. **Mental Health Nursing experience:** Practice may be clinical, educational, academic, management, health administration, research, consultancy, policy or advisory (public or private) and must be within, directly concerned with, or have a key focus on mental health.

The minimum standard for experience is that you have practiced for at least 12 months FTE (1824 hours based on 38 hours per week over 48 weeks) experience in mental health since graduating from a specialist/post graduate mental health nursing/psychiatric nursing program identified in b) above, or the equivalent of three years FTE (5472 hours) as a registered nurse in mental health.

Some of the experience you have undertaken in mental health must be recent. You must have practiced for at least 3 months (456 hrs) over the last year, 6 months (912 hrs) over the last 2 years, or 12 months (1824 hrs) over the last 3 years.

AND

who practices autonomously. That is, the mental health nurse decides who they accept for intervention, what intervention is provided and when discharge from care is appropriate.

Participants will be requested to declare how they meet the criteria. This will be taken at face value, that is documentary evidence will not be requested however information supplied on the demographic data form will provide some evidence, albeit self-declared.

The issue of determining autonomous practice will also be by self-evaluation using the above definition in the eligibility criteria. That is, participants will determine that the nature of their practice is one that is based on their own judgment and decision making about what clients they accept based on their self-assessed competence in dealing with the presenting issue. Further, independent assessment by the mental health nurse determines what interventions they are competent in delivering affecting a decision to engage the client with these interventions and also deciding at what point intervention will cease.

The underlying assumption is that the mental health nurse takes sole responsibility and accepts accountability for their practice throughout the process of engagement with their client.

It is likely that mental health nurse participants will be those in private or independent practice, perhaps in remote areas where they are the only decision maker in terms of their practice or perhaps in nurse-led facilities where the decision for entry is nursing driven.

Where participants practise totally independently, their ability to participate will be their own decision. Where participants are employees of another body, their involvement may be dependent upon approval from their employer in terms of available time and in some cases, via further local ethics approval.



## Appendix 5 - Eligibility Criteria for Participants who have had some Engagement with a Mental Health Nurse

**STUDY TITLE: What's Special about Mental Health Nursing? A Grounded Theory study**

You are eligible to participate in this study if you have had some professional involvement with a mental health nurse in the past 12 months and are willing to comment on what it is that they provide in terms of care and treatment. Therefore, you are either:

1. A current or past client of a mental health nurse and have engaged in a therapeutic relationship and can comment on your perception of the things that have helped you. ***You are not expected to disclose any details about your personal life*** but rather are able to comment on what the mental health nurse has done to help you.

OR

2. A relative, friend or carer for a client of the mental health nurse for whom the mental health nurse has provided some service. ***You are not expected to disclose any details about your personal life or the personal life of the client*** but can comment on what the mental health nurse has done to help you.

OR

3. A health care or other worker who has worked collaboratively with the mental health nurse, either directly or indirectly and can comment knowingly about the interventions employed by the mental health that have had a positive outcome.

## **Appendix 6 - Interview Schedule for Mental Health Nurse Participants – Semi Structured Interviews**

### **STUDY TITLE: What's Special about Mental Health Nursing? A Grounded Theory study**

The following information provided by you will be used to explore the nature of mental health nursing interventions and their consequences in terms of client outcomes. This information will help develop a model of mental health nursing that attempts to identify the profession's distinct contribution to mental health care.

Specifically, the research aims, at one level, to elucidate what it is that nurses do, what interventions they engage in their practice, and what positive client outcomes result from this practice. At another level, it attempts to elucidate what is distinctive or special about this practice; defining whether there is something special about mental health nursing not shared by other disciplines.

**Sample questions:** These are a guide only and interviews would not be restricted to these questions if new information needed to be explored that was relevant to the research questions. Information of a personal nature would not be explored as the phenomenon under study is the professional nature of the interactions. The same or similar questions could be used for focus groups if utilised.

Consider some examples of client interactions, current or past, that have yielded positive outcomes, from your evaluation.

1. Can you please describe these case studies in terms of the positive outcomes achieved?
2. How have you determined that the outcome has been a positive one?
3. What evidence or examples do you have to support this?
4. Taking each case example one at a time, what interventions did you employ that resulted in the positive outcomes?
5. Were these interventions evidence-based interventions and if so, what is the evidence base?
6. What type of training/experience have you had to employ these interventions?
7. Is there a philosophical or values base for these interventions? This can be formal 'accepted' interventions or informal ones you have employed to effect an outcome for your client?

## **Appendix 6 continued**

8. Could anyone else in your professional network have employed these interventions in the same way that you have?

If not, why not?

9. What has been your distinctive contribution to the positive outcome for your client?

10. What limits are there to your practice in terms of interventions that you can employ?

11. Are there interventions you use that are not used by or cannot be used by other disciplines and if so, what are they?

12. Would you describe your interventions as 'nursing' interventions? If so, why? If not, why?

## Appendix 7 - Interview Schedule for Other Participants – Semi Structured Interviews

### **STUDY TITLE: What's Special about Mental Health Nursing? A Grounded Theory study**

The following information provided by you will be used to explore the nature of mental health nursing interventions and their consequences in terms of client outcomes. This information will help develop a model of mental health nursing that attempts to identify the profession's distinct contribution to mental health care.

Specifically, the research aims, at one level, to elucidate what it is that nurses do, what interventions they engage in their practice, and what positive client outcomes result from this practice. At another level, it attempts to elucidate what is distinctive or special about this practice; defining whether there is something special about mental health nursing not shared by other disciplines.

**Sample questions:** These are a guide only and interviews would not be restricted to these questions if new information needed to be explored that was relevant to the research questions. Information of a personal nature would not be explored as the focus of the study is the professional nature of the interactions. The same or similar questions could be used for focus groups if utilised.

1. Is it possible for you to think about some examples of interactions with the mental health nurse, current or past that have, from your point of view, left you with a positive outcome?
2. Can you please describe these in terms of the positive outcomes achieved?
3. How do you determine that the outcome has been a positive one? Can you please talk me through in your own words your understanding of this and give some specific examples?
4. Taking each case example one at a time, what interventions were employed that resulted in the positive outcomes?
5. Bearing in mind that we are talking specifically about the work done by a mental health nurse, could anyone else *other than* the mental health nurse, as far as you know, have delivered on these interventions for the same result?  
If not, why not?
6. Has there been anything special about your interaction with the mental health nurse with whom you have been engaged and if so, what?

## Appendix 8 - Demographic Data Set for Mental Health Nurse Participants

**1. INTERVIEWEE REFERENCE NUMBER<sup>29</sup>:** .....

(Individual identification code assigned for each respondent)

**2. AGE:** (Please circle)

- 1) 21-30
- 2) 31-40
- 3) 41-50
- 4) > 50

**3. GENDER:** (Please circle)

- 1) *Male*
- 2) *Female*

**4. POSITION STATUS:** (Please circle)

- 1) *Registered Nurse- Mental Health*
- 2) *Credentialed Mental Health Nurse*
- 3) *Clinical Nurse Specialist*
- 4) *Nursing Manager*
- 5) *Nurse Practitioner*
- 6) *Other (specify).....*

**5. LENGTH OF EXPERIENCE AS A MENTAL HEALTH NURSE:**

***How long have you worked as a mental health nurse? (full-time equivalent)***

(Please circle)

- 1) *Less than 5 years*
- 2) *5 years*
- 3) *6-10 years*
- 4) *11-15 years*
- 5) *16 – 25 years*
- 6) *More than 25 years*

**6. CURRENT WORK SETTING:**

***In what area of mental health nursing do you work?***

(Please circle 1 or more as appropriate)

- 1) *Acute in-patient unit*
- 2) *Other in-patient unit ( specify) .....*
- 3) *Community- based team (specify) .....*
- 4) *Non-government organization*
- 5) *Mental Health Nurse Incentive Program*
- 6) *Primary Care as an employee*
- 7) *Primary Care as an independent practitioner*
- 8) *Other (specify) .....*

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<sup>29</sup> Allocated by the researcher

## Appendix 8 continued

### 7. LENGTH OF EXPERIENCE IN CURRENT WORK SETTING:

***How long have you worked in your current work setting? (full-time equivalent)*** (Please circle)

- 1) *Less than 5 years*
- 2) *5 years*
- 3) *6-10 years*
- 4) *11-15 years*
- 5) *More than 15 years*

### 8. QUALIFICATIONS:

***What is your qualification for mental health nursing?***

(Please circle as many as appropriate)

- 1) *Hospital-based Psychiatric Nursing Certificate*
- 2) *Diploma of Applied Science (Nursing)*
- 3) *Bachelor of Nursing*
- 4) *Post basic qualification in mental health nursing(specify) .....*
- 5) *Other (specify) .....*

### 9. WORK SETTING EXPERIENCE:

***Indicate any of the following areas of mental health nursing in which you have worked for a period of 1 year or more prior to your current work location.***

(Please circle as many as appropriate)

- 1) *Acute in-patient unit*
- 2) *Other in-patient unit ( specify) .....*
- 3) *Community-based team (specify) .....*
- 4) *Non-government organization*
- 5) *Mental Health Nurse Incentive Program*
- 6) *Primary Care as an employee*
- 7) *Primary Care as an independent practitioner*
- 8) *Other (specify) .....*

## Appendix 9 - Survey Questionnaire for Other Participants

### **STUDY TITLE: What's Special about Mental Health Nursing? A Grounded Theory study**

The following information provided by you will be used to explore the nature of mental health nursing interventions and their consequences in terms of client outcomes. This information will help develop a model of mental health nursing that attempts to identify the profession's distinct contribution to mental health care.

Specifically, the research aims, at one level, to elucidate what it is that nurses do, what interventions they engage in their practice, and what positive client outcomes result from this practice. At another level, it attempts to elucidate what is distinctive or special about this practice; defining whether there is something special about mental health nursing not shared by other disciplines.

Considering some examples of interactions, current or past, that have yielded helpful outcomes, from your evaluation, by the mental health nurse with which you have been engaged:.

1. Can you please describe these in terms of the positive outcomes achieved?
2. Taking each case example one at a time, what interventions were employed that resulted in the positive outcomes?
3. Could anyone else other than the mental health nurse with whom you were involved, as far as you know, have employed these interventions for the same result?  
If not, why not?
4. How do you determine that the outcomes have been a positive one? Can you give some specific examples?
5. Has there been anything special (that is, different or distinctive) about your interaction with the mental health nurse with whom you have been engaged and if so, what?

## Appendix 10: Ethics approval letter

Office of Research Services  
University of Tasmania  
Private Bag 1  
Hobart Tasmania 7001  
Telephone + 61 3 6226 7479  
Facsimile + 61 3 6226 7148  
Email HumanEthics@utas.edu.au  
www.research.utas.edu.au/human\_ethics/

HUMAN  
RESEARCH  
ETHICS  
COMMITTEE  
(TASMANIA)  
NETWORK



28 February 2012

Professor Nicholas Procter  
Chair, Mental Health Nursing  
University of New South Wales

Sent via Email

Dear Professor Procter,

REF NO: H12138

TITLE: What's special about mental health nursing? A Grounded Theory study

- Application Form- Tasmania Health and Medical Low Risk (version dated 2 February 2012)
- Protocol
- Appendix 1 Eligibility Criteria for Mental Health Nurse Participant
- Appendix 2 Eligibility Criteria for Participants who have had some engagement with a mental health nurse
- Appendix 3 Interview Schedule for mental health nurse participants- semi structured interviews
- Appendix 4 Interview schedule for participants who have had some professional involvement with a mental health nurse- semi structured interviews
- Appendix 5 Demographic information on mental health nurse participants
- Appendix 6 Survey questions for client participants who have had some professional involvement with a mental health nurse
- Appendix 10 Literature supporting justification for the study
- Information Sheet for mental health nurse participants, amended version dated 2 February 2012
- Information Sheet for participants who have had some engagement with a mental health nurse, amended version dated 2 February 2012
- Consent Form for other participants, amended version dated 2 February 2012
- Consent Form for mental health nurses, amended version dated 2 February 2012
- Appendix 11, guidelines for inviting others to participants, dated 1 December 2011
- Appendix 12, interview checklist dated 22 November 2011
- Appendix 13, compliance with section 4.5 of NSECHR

The Tasmania Health and Medical Human Research Ethics Committee considered and approved the above documentation on **17 February 2012**.

All committees operating under the Human Research Ethics Committee (Tasmania) Network are registered and required to comply with the *National Statement on the Ethical Conduct of Human Research* (NHMRC 2007).



A PARTNERSHIP PROGRAM BETWEEN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE UNIVERSITY OF TASMANIA

Therefore, the Chief Investigator's responsibility is to ensure that:

- (1) The individual researcher's protocol complies with the HREC approved protocol.
- (2) Modifications to the protocol do not proceed until **approval** is obtained in writing from the HREC.
- (3) Section 5.5.3 of the National Statement states:  
Researchers have a significant responsibility in monitoring approved research as they are in the best position to observe any adverse events or unexpected outcomes. They should report such events or outcomes promptly to the relevant institution/s and ethical review body/ies and take prompt steps to deal with any unexpected risks.  
The appropriate forms for reporting such events in relation to clinical and non-clinical trials and innovations can be located at the website below. All adverse events must be reported regardless of whether or not the event, in your opinion, is a direct effect of the therapeutic goods being tested. [http://www.research.utas.edu.au/human\\_ethics/medical\\_forms.htm](http://www.research.utas.edu.au/human_ethics/medical_forms.htm)
- (4) All research participants must be provided with the current Patient Information Sheet and Consent Form, unless otherwise approved by the Committee.
- (5) The Committee is notified if any investigators are added to, or cease involvement with, the project.
- (6) This study has approval for 4 years contingent upon annual review. A *Progress Report* is to be provided on the anniversary date of your approval. Your first report is due **16 February 2013**. You will be sent a courtesy reminder closer to this due date.
- (7) A *Final Report* and a copy of the published material, either in full or abstract, must be provided at the end of the project.

Should you have any queries please do not hesitate to contact me on (03) 6226 1956.

Yours sincerely

Akay

Adele Kay  
Acting Executive Officer  
Health and Medical Human Research Ethics Committee  
Human Research Ethics Committee (Tas) Network



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## **Appendix 11 - Consent Form for Mental Health Nurse Participants**

**Title of Project: What's Special about Mental Health Nursing? A Grounded Theory Study**

---

1. I have read and understood the 'Information Sheet' for this project.
2. The nature and possible effects of the study have been explained to me.
3. I understand that the study involves participating in interviews or focus groups and perhaps survey questionnaires if needed.
4. I understand that participation involves a commitment of time of about an hour's duration and that I may be contacted to participate in a follow-up interview or provide further information for clarification..
5. I understand that all research data will be securely stored in a locked cabinet in the office of the student investigator or a password protected computer for at least five years, and will then be destroyed.
6. Any questions that I have asked have been answered to my satisfaction.
7. I agree that research data gathered from me for the study may be published provided that I cannot be identified as a participant.
8. I understand that the researchers will maintain my identity confidential and that any information I supply to the researcher(s) will be used only for the purposes of the research.
9. I understand that the interviews will be audio-recorded for later analysis. However, if I do not wish the interview to be audio-recorded, all I need to do is to inform the researcher.
10. If the interview is not audio-recorded, the researcher will take notes of the interview. I also understand that a copy of either the notes taken in interview or the transcripts of the recorded interview can be made available to me at no cost.
11. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish, may request that any data I have supplied to date be withdrawn from the research.

---

Name of Participant:

---

Signature:

---

Date:

---

## Appendix 11 continued

### Statement by Investigator

- ☐ I have explained the project & the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

- ☐ The participant has received the Information Sheet where my details have been provided so participants have the opportunity to contact me prior to consenting to participate in this project.

Name of investigator \_\_\_\_\_

Signature of investigator \_\_\_\_\_

\_\_\_\_\_ Date

## **Appendix 12 - Consent Form for Other Participants invited by the Mental Health Nurse Participant**

**Title of Project: What's special about Mental Health Nursing? A Grounded Theory study**

---

1. I have read and understood the 'Information Sheet' for this project.
2. The nature and possible effects of the study have been explained to me.
3. I understand that the study involves participating in interviews or focus groups and perhaps survey questionnaires if needed.
4. I understand that participation involves a commitment of time of about an hour's duration and that I may be contacted to participate in a follow-up interview or provide further information for clarification..
5. I understand that all research data will be securely stored in a locked cabinet in the office of the student investigator or a password protected computer\_for at least five years, and will then be destroyed.
6. Any questions that I have asked have been answered to my satisfaction.
7. I agree that research data gathered from me for the study may be published provided that I cannot be identified as a participant.
8. I understand that the researchers will maintain my identity confidential and that any information I supply to the researcher(s) will be used only for the purposes of the research.
9. I understand that the interviews will be audio-recorded for later analysis. However, if I do not wish the interview to be audio-recorded, all I need to do is to inform the researcher.
10. If the interview is not audio-recorded, the researcher will take notes of the interview. I also understand that a copy of either the notes taken in interview or the transcripts of the recorded interview can be made available to me at no cost.
11. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish, may request that any data I have supplied to date be withdrawn from the research.

---

Name of Participant

---

Signature

---

Date

## Appendix 12 continued

Statement by the mental health nurse responsible for the care of the client

I have decided to invite this client to participate in this research having considered its potential benefits and both the client's willingness and capacity to participate. I believe that the consent is informed and that he/she understands the implications of participation.

\_\_\_\_\_  
Name of mental health nurse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of mental health nurse

### Statement by Investigator

☐ I have explained the project & the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have the opportunity to contact me prior to consenting to participate in this project.

Name of investigator \_\_\_\_\_

Signature of investigator \_\_\_\_\_ Date \_\_\_\_\_

## Appendix 13 – Presentations associated with this research

***What's special about mental health nursing? A Grounded Theory research proposal.***

Presentation to the University of Tasmania (UTAS) School of Nursing and Midwifery Graduate Research Symposium, August 2011, Hobart, Australia.

***What's Special about Mental Health Nursing – early themes and concepts.*** Presentation to the UTAS School of Nursing and Midwifery Graduate Research Symposium, 17 July 2012 in Launceston, Tasmania, Australia.

***Mental Health Nursing in Australia: Is there anything special about it?*** Presentation to Horatio: European Festival of Psychiatric Nursing, in Stockholm, Sweden, September 20-23, 2012.

***Putting together an identity that is mental health nursing – is it special?*** Presentation to Australian College of Mental Health Nurses (ACMHN) 38th International Conference in Darwin, Australia, October 2012.

'Abstracts', 2012, *International Journal of Mental Health Nursing*, vol. 21, pp. 1-28. 'Author Index', 2012, *International Journal of Mental Health Nursing*, vol. 21, pp. 29-29.

***Matching the methodology to the phenomenon of interest: A review of a mental health nursing study in progress.*** Presentation to the ACMHN inaugural on-line Research Symposium, 19 April 2013.

***Evaluating the quality of data collection and analysis in a Grounded Theory study.*** Presentation to the UTAS School of Nursing and Midwifery Graduate Research Symposium, 17 July 2013 in Launceston, Australia.

***Defining distinct mental health nursing practice: Help or hindrance to collaborative partnerships?*** Presentation to Australian College of Mental Health Nurses (ACMHN) 39th International Conference in Perth, Australia, October 2013.

'Australian College of Mental Health Nursing 39th International Mental Health Nursing Conference – Collaboration and Partnership in Mental Health Nursing', 2013, *International Journal of Mental Health Nursing*, vol. 22, pp. 1-38. 'Author Index', 2013, *International Journal of Mental Health Nursing*, vol. 22, pp. 39-39.

***Mental health nursing interventions in community & primary care settings: Stepped care or a distinct paradigm?*** Presentation to Horatio: European Festival of Psychiatric Nursing, in Istanbul, Turkey, October 31-November 2, 2013.

***Being in the here and now, side by side, co-constructing care: A substantive grounded theory of recovery-focused mental health nursing.*** Seminar presentation to the UTAS School of Health Science, Nursing and Midwifery, 29 July 2014 in Hobart, Australia.

***A theoretical construct of recovery-focused mental health nursing.*** Presentation to the 20th International Network for Psychiatric Nursing Research RCN Conference in Warwick, UK, September 2014.

***Shaping recovery-focused mental health nursing for the future: Report of a grounded theory study.*** Presentation to the Australian College of Mental Health Nurses (ACMHN) 40th International Conference in Melbourne, Australia, October 2014. Winner of the runner up to the Research Award for best research paper and featured in Nursing Review magazine, Issue 9, October 2014.

'Australian College of Mental Health Nurses 40th International Mental Health Nursing Conference – Honouring the Past, Shaping the Future', 2014, *International Journal of Mental Health Nursing*, vol. 23, pp. 1-45. 'Author Index', 2014, *International Journal of Mental Health Nursing*, vol. 23, pp. 46-4.

***Recovery-focused mental health nursing: Recent reform or renaissance?*** Presentation to University of Tasmania School of Health Science, Nursing and Midwifery Resilience, Recovery and Mental Health Conference 2014, 29 October 2014 in Hobart, Australia.

## **Appendix 14 - Participant Information Sheet for Mental Health Nurse Participants**

**STUDY TITLE: What's Special about Mental Health Nursing? A Grounded Theory study**

### **Invitation**

You are invited to participate in a research study exploring what may constitute distinctive mental health nursing practice and how this contributes to positive outcomes for whom or what it serves. The study is being conducted by:

- Chief Investigator: Professor Nicholas Procter
- Co-Investigator: Professor Denise Fassett
- PhD Student Investigator: Mr Pietro Santangelo

### **1. 'What is the purpose of this study?'**

The purpose is to develop a theoretical model of mental health nursing practice that helps define its distinctive contribution to mental health care and service delivery. The motivation for pursuing this research stems from an enduring inquiry within the profession of mental health nursing that, while mental health nurses engage in a variety of professional activities, they are unable to articulate clearly exactly what a mental health nurse is. This identity inquiry persists in a form that wonders whether the profession of mental health nursing is merely an amalgam of other disciplines or whether it possesses characteristics that have a distinct influence on who and what it serves – in short, is it special?

### **2. 'Why have I been invited to participate in this study?'**

You are eligible to participate in this study because you are mental health nurse with specialist mental health nursing qualifications and experience and who practices autonomously. That is, you decide who you accept for intervention, what intervention is provided and when discharge from care is appropriate. The researcher is interested in determining, from practitioners such as yourself, what it is that you do that is distinctive in your practice and how this has a positive outcome for the people you see.

### **4. 'What does this study involve?'**

You will be invited to participate in an interview, of about one hour's duration, in which the researcher will ask you a number of questions about the work you do as a mental health nurse. The particular focus of the questions will relate to those interventions that have a positive outcome. Alternatively, a focus group of mental health nurses may be convened to achieve the same purpose. In addition, you will be requested to complete a form outlining a profile of you, your work and qualifications. The researcher may also request further information for clarification of information already given which may or may not involve a further interview or focus group.

## **Appendix 14 continued**

The interviews will be audio-recorded and these recordings will later be transcribed for analysis. If the researcher does not transcribe the recordings personally, any recordings sent to a transcriber will be de-identified prior to being sent. Each recording will be given an alpha-numeric code known only to the researcher so that the identity of the interviewee remains anonymous.

If you do not wish the interview to be audio-recorded, all you need to do is to inform the researcher. The researcher will also confirm with you, prior to commencement of the interview, if you are happy for the session to be recorded.

If the interview is not audio-recorded, the researcher will take notes of the interview for later analysis. Whether or not the interview is audio-recorded, a copy of either the notes taken in interview or the transcripts of the recorded interview can be made available to you at no cost.

Each individual participant will be given a alpha numeric code that will appear on their interview schedule, transcripts of interviews and on demographic data where applicable.

Identifying details of participants will only be accessed for contact details in order to facilitate follow-up interviews.

All notes, other media and transcripts of interviews will be used by the researchers only, will be de-identified and kept in a locked cabinet in the office of the student researcher or in a password protected computer.

It is important that you understand that your involvement in this study is voluntary. While we would be pleased to have you participate, we respect your right to decline. There will be no consequences to you if you decide not to participate. If you decide to discontinue participation at any time you may do so without providing an explanation. All information will be treated in a confidential manner, and your name will not be used in any publication arising out of the research. All of the research will be kept in a locked cabinet in the office of the student investigator or in a password protected computer.

### **5. Are there any possible benefits from participation in this study?**

This study aims to contribute new knowledge and understanding about the positive and distinct contribution of mental health nursing practice. It is possible that the findings from this study may lead to further valuable research and inquiry, or perhaps more focused education and training for the profession in order to achieve better outcomes for consumers of mental health services. Your contribution will be the basis from which the study findings will arise and as such, most valuable.

### **6. Are there any possible risks from participation in this study?**

There are no specific risks anticipated with participation in this study. However, if you find that you are becoming distressed or upset that is not reconcilable with the researcher, you will be advised to receive support from local services available or alternatively, we will arrange for you to see a counsellor at no expense to you.

## **Appendix 14 continued**

### **7. What if I have questions about this research?**

If you would like to discuss any aspect of this study please feel free to contact the Student Investigator on 0438 479392 or alternatively the Chief Investigator on (08) 8302 2148 or Co-Investigator on (03) 6324 3741 We would be happy to discuss any aspect of the research with you. Once we have analysed the information we will be mailing / emailing you a summary of our findings. You are welcome to contact us at that time to discuss any issue relating to the research study.

This study has been approved by the Tasmanian Health and Medical Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study should contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au). The Executive Officer is the person nominated to receive complaints from research participants. You will need to quote HREC project number H12138.

**Thank you for taking the time to consider this study.**

**If you wish to take part in it, please sign the attached consent form.**

**This information sheet is for you to keep**



## **Appendix 15 - Participant Information Sheet for Other Participants**

**STUDY TITLE: What's Special about Mental Health Nursing? A Grounded Theory study**

### **Invitation**

You are invited to participate in a research study exploring what may constitute distinctive mental health nursing practice and how this contributes to positive outcomes for whom or what it serves. The study is being conducted by:

- Chief Investigator: Professor Nicholas Procter
- Co-Investigator: Professor Denise Fassett
- PhD Student Investigator: Mr Pietro Santangelo

### **2. 'What is the purpose of this study?'**

The purpose is to develop a theoretical model of mental health nursing practice that helps define its distinctive contribution to mental health care and service delivery. The motivation for pursuing this research stems from an enduring inquiry within the profession of mental health nursing that, while mental health nurses engage in a variety of professional activities, they are unable to articulate clearly exactly what a mental health nurse is. This identity inquiry persists in a form that wonders whether the profession of mental health nursing is merely an amalgam of other disciplines or whether it possesses characteristics that have a distinct influence on who and what it serves – in short, is it special?

### **2. 'Why have I been invited to participate in this study?'**

You are eligible to participate in this study because you have professional involvement with a mental health nurse in some capacity and can comment on what it is that they provide in terms of positive care and treatment.

### **4. 'What does this study involve?'**

You will be invited to participate in an interview, or alternatively a focus group, as someone who has engaged with a mental health nurse and can comment on the work that they do. The session would be for about an hour and some pre-set questions would help facilitate the discussion. If you do not wish to participate in an interview or focus group, you can complete a survey questionnaire should you still wish to participate. The researcher may also request further information for clarification of information already given which may or may not involve a further interview or focus group.

If you do not wish the interview to be audio-recorded, all you need to do is to inform the researcher. The researcher will also confirm with you, prior to commencement of the interview, if you are happy for the session to be recorded.

## **Appendix 15 continued**

If the interview is not audio-recorded, the researcher will take notes of the interview for later analysis. Whether or not the interview is audio-recorded, a copy of either the notes taken in interview or the transcripts of the recorded interview can be made available to you at no cost.

Each individual participant will be given a alpha numeric code that will appear on their interview schedule, transcripts of interviews and on demographic data where applicable.

Identifying details of participants will only be accessed for contact details in order to facilitate follow-up interviews.

All notes, other media and transcripts of interviews will be used by the researchers only, will be de-identified and kept in a locked cabinet in the office of the student researcher or a password protected computer.

It is important that you understand that your involvement in this study is voluntary. While we would be pleased to have you participate, we respect your right to decline. There will be no consequences to you if you decide not to participate. If you decide to discontinue participation at any time you may do so without providing an explanation. All information will be treated in a confidential manner, and your name will not be used in any publication arising out of the research. All of the research will be kept in a locked cabinet in the office of the student investigator or a password protected computer.

### **5. Are there any possible benefits from participation in this study?**

This study aims to contribute new knowledge and understanding about the positive and distinct contribution of mental health nursing practice. It is possible that the findings from this study may lead to further valuable research and inquiry, or perhaps more focused education and training for the profession in order to achieve better outcomes for consumers of mental health services. Your contribution will be the basis from which the study findings will arise and as such, most valuable.

### **6. Are there any possible risks from participation in this study?**

There are no specific risks anticipated with participation in this study. However, if you find that you are becoming distressed or upset that is not reconcilable with the researcher, you will be advised to receive support from local services available or alternatively, we will arrange for you to see a counsellor at no expense to you.

### **7. What if I have questions about this research?**

If you would like to discuss any aspect of this study please feel free to contact the Student Investigator on 0438 479392 or alternatively the Chief Investigator on (08) 8302 2148 or Co-Investigator on (03) 6324 3741. We would be happy to discuss any aspect of the research with you. Once we have analysed the information we will be mailing / emailing you a summary of our findings. You are welcome to contact us at that time to discuss any issue relating to the research study.

## **Appendix 15 continued**

This study has been approved by the Tasmanian Health and Medical Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study should contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au). The Executive Officer is the person nominated to receive complaints from research participants. You will need to quote HREC project number: H12138.

**Thank you for taking the time to consider this study.**

**If you wish to take part in it, please sign the attached consent form.**

**This information sheet is for you to keep**

## **Appendix 16: Expression of interest to participate in the research study: What's Special about Mental Health Nursing? A Grounded Theory Study**

Are you a mental health nurse with specialist mental health nursing qualifications and experience? Do you practice autonomously? That is, do you decide who you accept for intervention, what intervention is provided and when discharge from care is appropriate? If you answered **'yes'** to each of these questions then I am keen to meet and talk with you as part of my PhD research about what it is that you do that is distinctive in your practice and how this has a positive outcome for the people you see.

The study is being conducted by:

- Chief Investigator: Professor Nicholas Procter
- Co-Investigator: Professor Denise Fassett
- PhD Student Investigator: Mr Peter Santangelo

The purpose is to develop a theoretical model of mental health nursing practice that helps define its distinctive contribution to mental health care and service delivery. The motivation for pursuing this research stems from an enduring inquiry within the profession of mental health nursing that, while mental health nurses engage in a variety of professional activities, they are unable to articulate clearly exactly what a mental health nurse is. This identity inquiry persists in a form that wonders whether the profession of mental health nursing is merely an amalgam of other disciplines or whether it possesses characteristics that have a distinct influence on who and what it serves – in short, is it special?

Your participation will involve a confidential interview (about 1 hour) and no participants are identified. Should you be interested, you are of course under no obligation and can decide once you have read the relevant information about the study.

If you are interested, please provide your contact details below and Mr Santangelo will contact you and send you the formal Information Sheet about the research, Eligibility Criteria for participants, a Consent Form and any other information you may wish. You are also welcome to contact Mr Santangelo for any other information prior to providing your contact details to clarify any issue about your participation. Mr Santangelo is contactable on mobile: 0438 479392 or by email: [psantangelo@bigpond.com](mailto:psantangelo@bigpond.com)

This study has been approved by the Tasmanian Health and Medical Human Research Ethics Committee on 17 February 2012, reference number: H12138.

**THANK YOU FOR CONSIDERING THIS INVITATION**

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**What's Special about Mental Health Nursing? A Grounded Theory Study**

**EXPRESSION OF INTEREST TO PARTICIPATE IN THE ABOVE STUDY**

Name: .....

Contact number: .....

Email: .....

## Appendix 17: Screen shot of developed nodes in NVivo software

The screenshot displays the NVivo software interface with the 'Nodes' tab selected. The main window shows a list of nodes organized into a tree structure on the left and a detailed table on the right. The table columns are: Name, Sources, References, Created On, Created By, Modified On, and Modified By.

Name	Sources	References	Created On	Created By	Modified On	Modified By
autonomous practice	18	30	2/08/2012 9:13 PM	PS	16/08/2013 1:50 PM	PS
Clinical decision making	1	1	12/08/2013 8:21 PM	PS	12/08/2013 8:22 PM	PS
Co-construction in therapy	2	5	15/08/2013 11:42 AM	PS	15/08/2013 1:47 PM	PS
Context of care	20	48	19/08/2012 10:27 PM	PS	16/08/2013 3:34 PM	PS
MH/Ning culture	13	21	2/08/2012 4:44 PM	PS	16/08/2013 12:04 PM	PS
Distinctive nursing practice	19	48	19/08/2012 10:20 PM	PS	15/08/2013 2:37 PM	PS
MH/Ning as different	23	37	12/12/2012 3:42 PM	PS	12/07/2014 8:26 PM	PS
MH/Ning identity	22	41	17/08/2012 8:59 PM	PS	16/08/2013 2:27 PM	PS
Interventions	22	42	11/12/2012 11:37 AM	PS	16/08/2013 3:13 PM	PS
nursing specific interventions	16	36	2/08/2012 9:04 PM	PS	5/09/2013 3:38 PM	PS
Unlabeled interventions	8	16	19/08/2012 10:50 PM	PS	16/08/2013 10:30 AM	PS
Learning	6	9	12/12/2012 3:07 PM	PS	16/08/2013 11:22 AM	PS
Breadth of practice and learning	1	4	15/08/2013 11:36 AM	PS	15/08/2013 11:46 AM	PS
Educational opportunities	3	3	13/08/2013 1:56 PM	PS	15/08/2013 1:06 PM	PS
Experience as teacher	23	45	22/08/2012 8:21 PM	PS	12/07/2014 8:26 PM	PS
models of care	11	19	2/08/2012 4:51 PM	PS	16/08/2013 1:26 PM	PS
Holistic care	4	4	13/08/2013 1:47 PM	PS	15/08/2013 2:39 PM	PS
Modes of practice	14	22	7/08/2012 2:10 PM	PS	15/08/2013 1:16 PM	PS
Collaborative practice	24	40	1/09/2012 1:11 PM	PS	10/09/2013 12:29 PM	PS
Flexibility of practice	14	23	19/08/2012 10:59 PM	PS	16/08/2013 3:33 PM	PS
Persistence and tenacity	8	13	1/09/2012 12:46 PM	PS	16/08/2013 3:22 PM	PS
Practice boundaries	18	35	19/08/2012 12:46 PM	PS	16/08/2013 10:42 AM	PS
Therapeutic use of self	10	16	19/08/2012 12:48 PM	PS	16/08/2013 3:31 PM	PS
Therapy through interaction	17	26	11/12/2012 12:00 PM	PS	12/07/2014 8:26 PM	PS
Time to give	16	28	11/12/2012 11:46 AM	PS	16/08/2013 3:24 PM	PS
nursing interaction	12	31	2/08/2012 4:43 PM	PS	26/06/2013 4:22 PM	PS
Being there	3	6	16/08/2013 2:34 PM	PS	16/08/2013 3:24 PM	PS
Outcomes	32	69	7/08/2012 2:06 PM	PS	16/08/2013 3:48 PM	PS
Philosophies of nursing - care	5	7	13/08/2013 2:02 PM	PS	12/07/2014 8:26 PM	PS
Client focus	19	31	19/08/2012 11:05 PM	PS	12/07/2014 8:26 PM	PS
Normalising care	2	2	13/08/2013 1:49 PM	PS	16/08/2013 2:35 PM	PS
Positive mindfulness	7	9	1/09/2012 3:24 PM	PS	12/07/2014 8:26 PM	PS
Scope of practice	14	20	19/08/2012 12:52 PM	PS	16/08/2013 3:39 PM	PS
Stigma	4	7	11/12/2012 11:25 AM	PS	16/08/2013 3:38 PM	PS

## **Appendix 18: Example of memo**

### **4 April 2012 - Memo re interviews with mental health nurse participants 2 and 3.**

Interview with G – One of the first things she said was that she wanted to stress very clearly that what she did as a practitioner was very much based on her nursing experiences. The sorts of things she was able to do in terms of positive outcomes with people was because she was a nurse - that was the experience that she had. I got a sense this whole issue around having a grounding in this profession gave access to people and close contact with them; close contact, not just in doing for them as a nurse does, but actually engaging with them as a person. So it's that notion of engagement by default, I suppose, that you're doing very ordinary things with people. I am hearing that clients' perception of nurses is that they are pretty much on the same level as them. The opportunity to engage with people on an equal level becomes easier and as a result and that level of engagement also becomes more therapeutic, even though there are plenty of examples where there is a strong power differential when clients are engaging with a nurse.

The other allusion in the conversation with G was about the breadth of experience that nurses have that you don't tend to see in other disciplines. Other disciplines tend to have a certain focus and she specifically referred to having a scientifically dominated or guided background whereas nurses engage in a whole host of things – social, spiritual, scientific, medical etc., and personal in some ways. Also this other sense of an underlying philosophy of having hope – G seemed to align that very closely with nursing and saw that as an enduring philosophy that guided the way nurses practiced.

Interview with J – slightly different – both these MHNs are working in independent practice and have done so for a number of years. J describes his practice, over a long period of time, as being more entrepreneurial and a lot of that being business oriented and involved with management stuff from which he has made a very comfortable living. But it wasn't enough to provide ongoing satisfaction – he needed to know that he was contributing towards a need somewhere. When I asked him about mental health nursing and whether his practice actually comes from nursing, he was quite definite and assertive that it did. It was because of mental health nursing that he was able to do the things he did. He saw that what he did was pretty distinctive. He doesn't see any other professional working in the way he does or doing the sort of things he does and he was inclusive of mental health nursing in that – some mental health nurses don't do what he does either.

I got the impression that he has had a lot of contact with mental health nursing since his training days because he refers to the context of his other nursing practice in large hospitals. Certainly his work-scape is much more diverse than that these days. He was really talking about the license to be able to work to the edges of the scope of practice for mental health nursing because he mentioned a couple of times that, as long as you work within the guidelines, that things are OK. But beyond that, the sky was the limit. And that was the same sort of message that I got from G as well. That as long as you are trained and qualified and confident, you've got the skill to be able to perform a certain intervention, then mental health nursing culturally allows that to happen. Other disciplines can be more restrained in that respect.

## Appendix 18 continued

So there seemed to be some themes of:

1. The breadth of experience that people have as nurse that they may not have been afforded if they had followed a different career path;
2. The closeness of contact with people and doing with people ordinary things that are not necessarily prescribed by having to execute specific skilled tasks because that is the training that you have had;
3. So there is this flexibility in the way in which mental health nurses can work with and engage with people and thereby that increases the depth of engagement and the intimacy of the professional relationship they have;
4. Both G and J talked about the boundaries within which they operate and in some respects, G had very clear boundaries determined by the psychoanalytic or psychodynamic approach; having a prescribed amount of time to work with people, being consistent with them in terms of being there without them needing to know anything about her personally. So there was this notion of consistency and reliability being important and those boundaries being in place to preserve those, and yet on the other hand, feeling that she could follow her own intuition to do things that other professionals would not do. At one point she mentioned she was congratulated by another psychoanalytic psychotherapist who saw her engagement with a client outside of the office, taking the person for coffee and doing those sorts of things. This case study is described in her conference paper as having the courage to venture outside of those boundaries because it was driven by good therapeutic intent and eventually good therapeutic outcomes.

J similarly confines himself to boundaries of certain practice and yet will do that in a diversity of settings and is very willing to follow his own intuition about what is going to work best. He described particular activities with clients that involved his other passion, that is, boxing. He chooses his clients very carefully for those that would benefit from that sort of physical activity and that sort of engagement. Interestingly he referred to his qualification, as a boxing trainer, as giving him the license to be able to touch people as part of that training process. We have always thought, that in nursing, that we have some license to touch people because we need to engage physically with them in meeting certain aspects of their needs. But mental health nurses would treat that with a little more caution because of the implication of this being intrusive upon the person or assaultive in some way.

I talked to both J and G about my own perspective in doing this research and said that I wasn't coming from any particular perspective or particular viewpoint in relation to what mental health nursing is. In many ways, I am exploring the territory because I genuinely don't have a consolidated view of that and that was my interest in this particular research; that there is an enduring debate about mental health nursing and I was interested in following through that phenomenon and getting some information from people who are living the experience of being a mental health to try to get some clarity or concepts around what mental health nursing is. I also broached the issue of keeping engaged with them as participants through a Bulletin to which they could contribute ideas if they wanted and both were happy about that.

## Appendix 18 continued

I was impressed by both interviews and the work they were doing. Obviously each of them was getting a lot of rewards with seeing changes in the people they are working with, enjoying what they do and doing it with a lot of confidence and identifying themselves professionally as a mental health nurse in the process. In fact G talked about the Mental Health Nurse Incentive Program as the program that helped facilitate giving mental health nursing its name back in terms of the psychotherapeutic work that they do. She was particularly proud of the work she did with people with enduring mental illness because no-one else seemed to have the capacity or the facility to be able to do that, because they don't have the mind set to be able to deal with it. She talked about other disciplines feeling uncomfortable with people who are psychotic and yet that barrier is mostly broken with mental health nurses. Well certainly for her it was, and she didn't feel uncomfortable at all in terms of being able to engage and then elicit what the person's needs were. Helping facilitate a recovery for them was made easier as a result.

In my previous Masters research, I referred to the term of 'therapeutic intimacy' which to me meant being able to share very closely a person's life, their emotions, and at the same time skirt on the edge of what are traditional boundary issues to ensure that some facilitative change takes place.

The other issue that was raised through this was whether any of the practices that these mental health nurses engage in are exclusive to mental health nursing as a profession. There was some ambivalence from G and J about that I think. On the one hand, they thought well, no, nothing is exclusive. But having given it a bit more thought, both referred back to the breadth of experience that mental health nursing had given them and how this opened up a whole diverse way of relating to people and intervening with them in positive and successful ways.



## Appendix 19: Category formulation from the data analysis

25 statements expressed as gerunds were assigned as properties of each domain. These were reviewed and re-framed into 19 statements (again expressed as gerunds) that formed the special properties of the major categories.

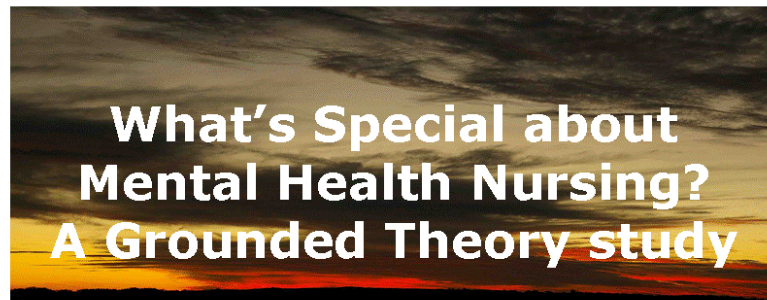
DOMAIN	PROPERTIES ASSIGNED TO DOMAINS	RE-FRAMED PROPERTIES	MAJOR CATEGORIES
Nature of mental health nursing	<ul style="list-style-type: none"> <li>• Apportioning meaning to mental tasks</li> <li>• Acknowledging client perspectives</li> <li>• Becoming and being a mental health nurse</li> <li>• Being there</li> <li>• Contextualising mental health nursing</li> <li>• Doing what no-one else will do</li> <li>• Interacting as a mental health nurse</li> <li>• Relating therapeutically</li> <li>• Seeing holistically</li> <li>• Tolerating challenging behaviours</li> </ul>	<ul style="list-style-type: none"> <li>• Becoming and being a mental health nurse</li> <li>• Constructing meaning to everyday tasks</li> <li>• Being there</li> <li>• Interacting therapeutically as a mental health nurse</li> <li>• Doing what no-one else will do</li> <li>• Seeing holistically</li> <li>• Acknowledging and respecting client perspectives</li> </ul>	Using the distinct nature of mental health nursing in the service of others
Scope of mental health nursing practice	<ul style="list-style-type: none"> <li>• Defining distinctive practice</li> <li>• Distinguishing distinctive practice</li> <li>• Making time and being flexible</li> <li>• Managing practice constraints</li> <li>• Modelling healthy activities</li> <li>• Practicing autonomously</li> <li>• Rising above its station</li> </ul>	<ul style="list-style-type: none"> <li>• Context of care potentiating mental health scope of practice</li> <li>• Relationship-based and client-focused nursing care</li> <li>• Making time and being flexible</li> <li>• Collaborating in care</li> <li>• Working holistically</li> <li>• Defining and distinguishing distinctive practice</li> </ul>	Working to the edge of practice boundaries with the client
Consequences of mental health nursing practice	<ul style="list-style-type: none"> <li>• Asserting nursing identity and status</li> <li>• Constructing therapy together</li> <li>• Collaborating for good outcomes</li> <li>• Evaluating outcomes</li> <li>• Getting clients established on the recovery pathway</li> <li>• Pulling it all together</li> <li>• Using evidence to guide interventions</li> <li>• Working with where they're at</li> </ul>	<ul style="list-style-type: none"> <li>• Determining appropriate outcomes through partnering</li> <li>• Collaborating for good outcomes</li> <li>• Working with where they're at to resolve client issues</li> <li>• Using varied evidence to guide intervention to achieve outcomes</li> <li>• Nursing clients on the recovery pathway</li> <li>• Asserting nursing identity, credibility and status through positive achievements</li> </ul>	Pulling together collaboratively developed interventions for positive outcomes

## Appendix 20: Progress Bulletin No 7



UNIVERSITY of  
TASMANIA  
Faculty of Health  
School of Health Sciences  
Nursing and Midwifery

**Bulletin No 7**  
**June 2014**



### *Developing a grounded theory on what is special about mental health nursing*

#### **Grounded theory**

Grounded theory is concerned with social and psychosocial processes and is underpinned by interpreting and attaching meaning to interactions of the actors involved. In the case of this research study, the area of interest is the professional interaction of mental health nurses with their clients and the special nature of their contribution to this process.

#### **Participant contribution and data analysis**

All participant interviews were transcribed and analysed. This involved reading each of the transcripts line by line and relevant extracts were assigned to a theme that reflected the meaning expressed in the data. In this way, data from participants were compared to each other from which conceptual ideas emerged. That is, interpretations of data were made that reflected common meanings across the data. Memos were written which consisted of reflective

thoughts about the phenomena and other issues that emerged from the data and from the research process. In addition and along with memos, diagrammatic representations of the issues and processes emerging served to stimulate conceptual thinking.

#### **The desired outcome**

The result of this analysis is an interpretation of what was revealed in participant interviews while being faithful to the voice of participants. This goes beyond a description of the data to formulate conceptual frameworks that contribute to a theory of mental health nursing practice.

#### **What is a theory?**

A theory is 'an internally consistent group of relational statements (concepts, definitions and propositions) that presents a systemic view about a phenomenon and which is useful for description, explanation, prediction and control. A theory, by

virtue of its predictive potential, is the primary means of meeting the goals of the nursing profession concerned with a clearly defined body of knowledge' (Walker & Avant 2011)

#### **Participant feedback**

In order to be true to the data contributed by participants, grounded theory method demands that developing concepts are tested with the participants in terms of coherence and relevance to their practice.

This serves to confirm and further refine development of conceptual categories. The dissemination of Progress Bulletins to participants is the mechanism used in this study to elicit feedback to achieve this aim.

Your interest and continued contribution to this study is very much appreciated and valuable.

**THANK YOU!**

*Walker & Avant 2011*

*Strategies for theory construction in nursing,*

Fifth edn, Prentice Hall, Boston.

***Regular bulletins will keep you updated with the progress of this research study.***  
***For further information, contact the researcher:***

Peter Santangelo on 0438 479392 or by email at:  
[psantangelo@bigpond.com](mailto:psantangelo@bigpond.com)

*Chief investigators:* Professors Denise Fassett and Nicholas Procter

## Appendix 21: Case example from participant

**MHN participant:** *When I was working in the community team, I had a lady on my case load who was a little bit older than me and her daughter had died in very tragic circumstances. She'd had flu and she ended up being brain dead, and this particular patient of mine was a nurse in that particular hospital where her daughter died and where her baby was born prematurely by C Section. So for three weeks she spent time at her workplace visiting her daughter in intensive care and looking after the grand daughter in Neonatal. And then the day that she turned the life support off on her daughter was the day she took the baby home to raise her.*

*She was on automatic pilot for a year and then she just fell apart. She was cutting herself really badly and was admitted to hospital. She was self-harming really badly and she had ECT; she was a tragic case. She used to live out in an outlying suburb. Anyway, she couldn't drive because she was just too damaged. She couldn't work, she had no money, she had no income, she couldn't pay her mortgage, she couldn't pay her bills, she just couldn't function. She couldn't cook, she couldn't drive, she couldn't raise the child and I ended up reporting her to the Department of Community Services because she was self-harming in front of the baby. She was cutting herself in front of the baby.*

*I got charities to help her over Christmas and to pay some bills and things. I used to go and sit in the room with her and talk to her and I knew everything I was saying was just going over her head. And she never left the room; never left the house. She was just piling on the weight and she was almost catatonic.*

*So I hit on an idea because I was stumped for things to do. So I said, "Next time I come, let's go for a walk". I had no idea where anything was in that suburb, so she showed me around. She would say "Let's go up there, or there". We got attacked by ducks and we got attacked by magpies and then it just became a part of my therapeutic interaction with her.*

**Researcher:** *But she readily acquiesced to going for a walk? And she had been pretty much withdrawn, and not wanting to move from her house? What was it that motivated her to say she would come for a walk with you?*

## Appendix 21 continued

**MHN participant:** *As a nurse she knew that exercise was important and so I would say, “You need to watch your diet” and all this stuff that you do, “Watch your diet, eat more healthily, need to go exercise, bla bla bla”. She didn’t do it. So we did meal plans, she didn’t do it. She didn’t do any of the exercises, so I decided I would just go and do it with her. At least then she would get her circulation going and she would get some fresh air. She wasn’t going to do it without me so I started doing it once a week and that ended up being the only time that she did go.*

*So instead of it just being a short walk around the block we made it an hour long walk through the paddocks and whatever, and it was just better for her to go for a long walk. We just talked. She came out of her shell and she came to trust me. I ended up doing some systematic desensitisation with her because she felt well enough to go back to work, but she was phobic about the hospital where she worked and so we’d do things like meet up at the entry. We would just sit at the entry until the anxiety went and then she would go home. Then we would go a bit further. I then engaged a Masters student who was there at the time to do that for me, because I couldn’t do it all the time. She took it on twice a week for a while and I would do it as well. I would sit in the chapel with her where she spent a lot of time. I ended up sitting outside ICU with her just to get the anxiety down. Then I went with her to meetings with the return to work officer and getting her a return to work plan.*

*This was all over about two and a half years. I ran into her about a year ago. She’s working full time again. The little girl is now 8 and she saw me and she said “Oooohhhh, Hi”, quite excitedly. She worked in Paediatrics and adolescents and she dealt a lot with kids who self-harm. She was really self-conscience about all her cuts on her wrist; they were really deep. They were deep right across and down, really deep scars and she was self-conscience about it and not sure how she would explain it to the kids she was looking after. So we talked about how she could address that. She ended up being really comfortable.*

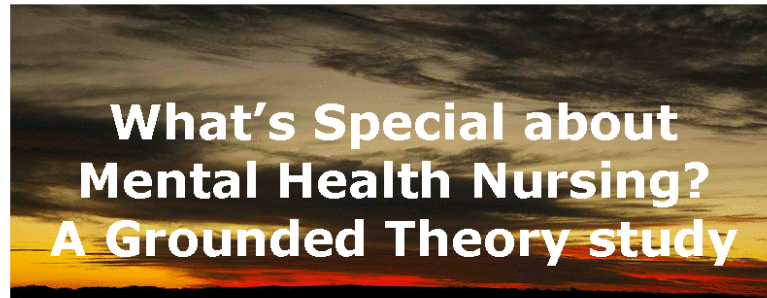
*She is back to being a Clinical Nurse Specialist and life is good for her. She’s still overweight. I don’t know if she does much exercise but mentally she’s good and her life is back on track. (MHN participant 5).*

## Appendix 22: Progress Bulletin No 10



UNIVERSITY of  
TASMANIA  
Faculty of Health  
School of Health Sciences  
Nursing and Midwifery

**Bulletin No 10**  
**June 2014**



### *A hypothesis about the special nature of mental health nursing*

#### **Nursing identity**

Nursing has been defined as a distinct contributor to health care since the time of Florence Nightingale. It has long since been consolidated in its own statutory regulation and has established specific and accredited curricula for learning. As such it has achieved professional status.

Mental health nursing has justifiably adopted its professional persona in nursing because it fits the frame of nursing work. However, the nature of that work and the culture of the setting in which it is applied has provided different challenges that generate a specialist application of nursing.

#### **Specialist practice**

The nature of mental illness/disorder presentations is different and less defined than physical illnesses and the determinants of mental illnesses are broader in aetiology and require specially devel-

oped skills in order to care for persons with such illnesses.

Finding the 'special' in the 'specialist' and explaining the phenomenon that is mental health nursing is the aim of this study.

#### **Attributes of care**

The nature of mental health nursing, as interpreted from participants' data in this study, drives practice that establishes a firm and trusting relationship with their clients. This facilitates the generation of ideas and actions that move towards the implementation of strategies for the outcome the client wants.

It is flexible in its practice and grounded in assisting clients meet their life challenges and not just their health issues. Mental health nurses, as a consequence, engage and give meaning to ordinary activities of living through negotiated and targeted interventions that are both professionally and client informed,

and pursued with therapeutic intent.

They have established their identity based on this experience of care and have moved beyond the confines of bio-medical paradigms to more inclusive ones that relate to the broad spectrum of living.

#### **Client focused care**

The nature of the relationship with clients is contractual and characterised by humility and the preparedness to go to lengths to achieve therapeutic outcomes that are often seen to be beyond the remit of other disciplines.

Mental health nurses have been in and learned from the privileged position of being with clients for prolonged periods of care, sensitising them to a broad gamut of health and life challenges with which they have grown accustomed and comfortable.

*The property of becoming and being a mental health nurse makes special reference to the influence of the 'service' aspects of its professional development and the way this has been adapted towards professional therapeutic benefit for those they serve .*

***Regular bulletins will keep you updated with the progress of this research study.***

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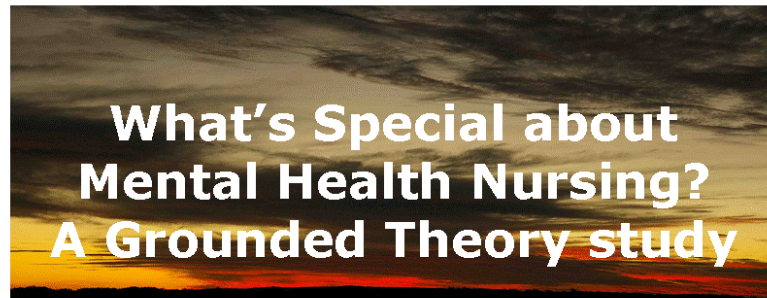
***Chief investigators:*** Professors Denise Fassett and Nicholas Procter

## Appendix 23: Progress Bulletin No 12



Faculty of Health  
School of Health Sciences  
Nursing and Midwifery

**Bulletin No 12**  
**June 2014**



### *A hypothesis about the scope of specialist mental health nursing practice*

#### **Self determination**

The breadth and depth of mental health nursing practice provides a distinct therapeutic contribution to mental health care. The scope of mental health nursing practice is determined, not by the prescription of other disciplines, and in particular medicine, but rather by taking cues from a variety of sources.

Mental health nurses identify strongly and positively with nursing as a profession and accept the sole responsibility and accountability for their distinct practice. As such, they provide an exemplar of both the potential and realisation of mental health nursing practice.

#### **Extending the bounds of practice**

They are also prepared, within the constraints of statutory limitations of their role, to practice to the very boundaries of their role in order to meet their professional and ethical responsibilities.

The mental health nurse participants in this study engaged in autonomous practice in settings that exposes them to diverse physical, psychological and social challenges. They engaged interventions based on their knowledge, skill and experience in this diverse range of challenges to provide integrated bio-psycho-social care.

This perspective of care is quintessentially nursing, related to its holistic world view. This particular perspective drives practice that seeks solutions in the broadest way, facilitating the range of resources required to achieve resolution of client needs through negotiation and collaboration.

#### **Beyond client centredness**

Mental health nurses rely on the relationship negotiated with their clients for a therapeutic outcome. It also relies on the client's contribution in communicating their needs and negotiating, in partnership, the nature and execution of interven-

tions to meet them. In this way, the relationship is a co-construction of the professional (for the nurse) and the personal (for the client) aspirations of both parties in harmony.

This engenders a different interpretation of the notion of 'client-focused'. More than considering the client as the centre of care, it depends on them to generate and affect that care. Using clients' direction to facilitate care is, in a real sense, in accord with recovery approaches to care.

#### **Intimacy and humility**

The privilege of therapeutic intimacy is founded in nursing experience, is woven into their professional modus operandi, and affords a coupling in care that and is distinct as a result.

The bounds of their professional practice are determined by the ethos and experience of care this peculiar orientation provides. It allows flexibility and breadth in practice that is extraordinary.

*Collaborative partnerships  
in mental health care is a  
core domain in supporting  
personal recovery*

(Australian Health Ministers'  
Advisory Council 2013)

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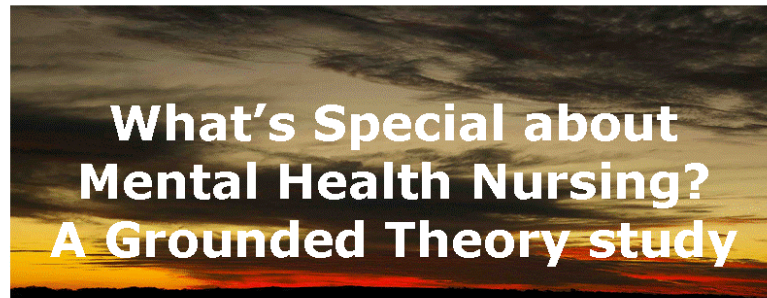


## Appendix 24: Progress Bulletin No 14



Faculty of Health  
School of Health Sciences  
Nursing and Midwifery

**Bulletin No 14**  
**June 2014**



### *What is special about the consequences of mental health nursing? A hypothesis*

#### **Determining outcomes: a shared experience**

Outcomes are not prescribed though the application of professional expertise as the dominant influence, but through a constructed and individualised interactive process with the client that acknowledges their rights, choices, wisdom and expertise in determining the best outcome for themselves. Working alongside clients in a close and intimate way is intrinsic to nursing practice

#### **Constructing and contracting care towards outcomes**

The outcomes that mental health nurses pursue from the beginning of their interaction with a client are not certain. Clarity and certainty grows as a result of the interaction, taking the time to be with and listen to the client's explanation of their challenges and how they are equipped to deal with them.

This process involves building a trusting relationship and inter-

preting nuances within it in order to determine what it is the client wants to achieve in terms of outcomes, and what capacity the nurse has to meet those needs. If this requires additional expertise and support, the nurse will pursue these in a coordinated and determined manner. So the process of determining outcomes is based on the interactive experience with the client, taking their cues to guide action.

#### **Collaborating for effective outcomes**

The mental health nurse is not alone in this work. They rely on the experience and expertise of the client and other health care disciplines to affect an outcome. They do, however, readily take on the responsibility of coordinating this care being mindful of their ethical duty to ensure that any and every intervention is for the benefit of the client. This responsibility is clear to nurses whose culture of caring is based on seeing a broad picture of the client's life and needs within it. Mental

health nurses are attuned to serve with the best capacity they have. They understand how, when and where different expertise and resources can contribute to an effective result that the client generates and aspires to and engage resources to meet these.

#### **Mutual benefits**

The consequences of mental health nursing practice has impact beyond the primary goal of positive client outcomes. Mutual benefit results for both the nurse and the client from their special interactional experience. In addition to the professional satisfaction that comes with facilitating positive outcomes for clients, effective results also reinforces the distinctive role, expertise, skill and knowledge that a nursing paradigm brings to mental health care that is specialist in nature, broad in its scope and potent in its influence. It provides clarity about the purpose, aim, identity and impact of this special contribution.

*Flexible health care systems are prepared to take risks to support a recovery approach where the agenda is about 'potential and expectation' rather than 'safety' alone.*

(Bonney & Stickley, 2008)

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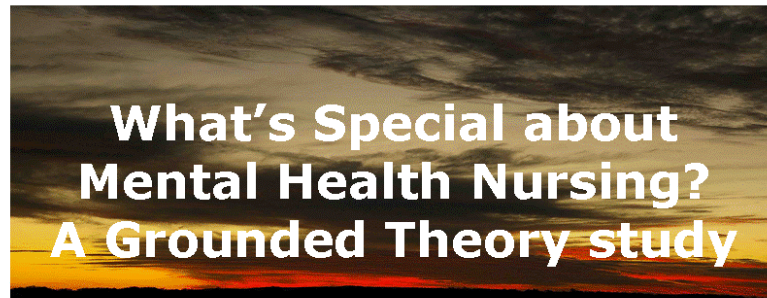
***Chief investigators:*** Professors Denise Fassett and Nicholas Procter

## Appendix 25: Progress Bulletin No 15



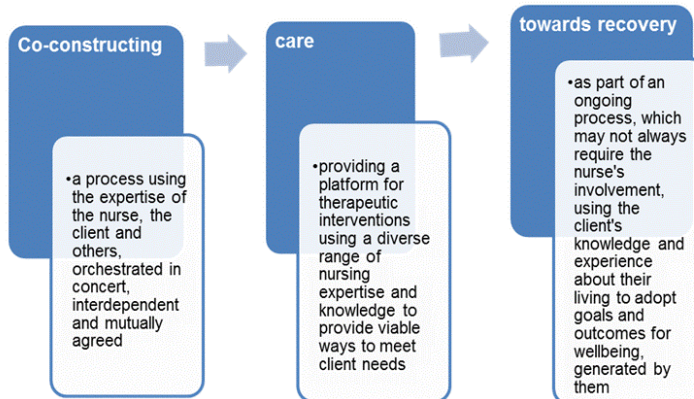
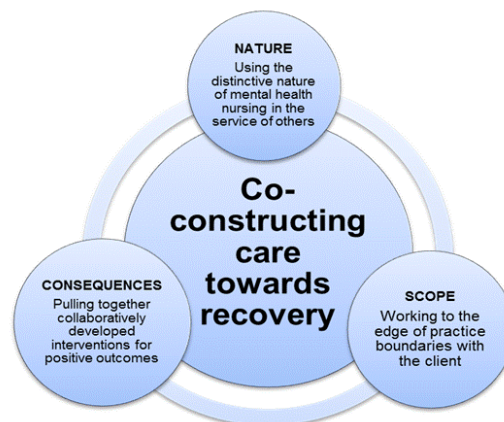
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**Bulletin No 15**  
**June 2014**



### *Defining a core concept of mental health nursing practice: co-constructing care towards recovery*

*The distinct nature and identity of mental health nurses drive their practice in a peculiar way that is based on an interaction with clients that is both special and productive in terms of positive consequences for the aspirational outcomes of both the clients and the nurse. That is, the nature of the profession of mental health nursing itself, its work and the relationship formed by nurses with clients, is an interdependent and interactive interplay that is special and productive.*



*Explanatory components of the core category are expressed in the diagram on the left.*

*Constructing practice in this way sensitises mental health nurses to being open to influences other than those professionally prescribed. The result is a therapeutic and beneficial coupling that is, concurrently, humanistic and professional, co-constructed and contractual, collaborative and purposeful, and empowering and power-sharing.*

Australian national mental health workforce strategy:

*To 'develop and support a well-led, high performing and sustainable mental health workforce delivering quality, recovery-focused mental health services'*

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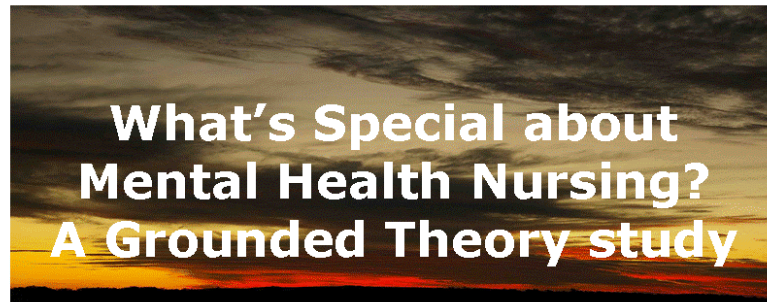


## Appendix 26: Progress Bulletin No 16

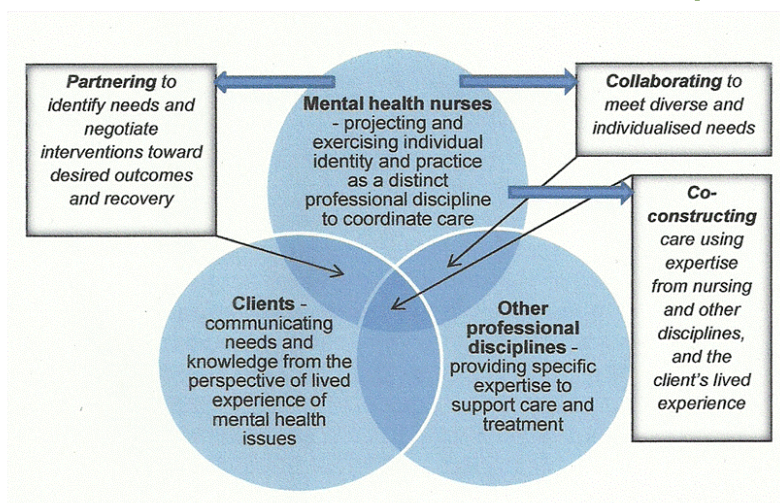


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**Bulletin No 16**  
**June 2014**



### *The psycho-social process of co-constructing care towards recovery*



In grounded theory methodology, a psycho-social process is formulated and explains the relationships in the phenomenon being explored.

It is supported by and interactive with the core category which in turn is supported and interactive with the sub-categories and their properties.

It serves to provide the foundation towards an integrated theory through further and advanced conceptual development.

Mental health nurses are depicted in the above process sharing responsibility and influence as one of three players. They are not alone in their practice and indeed rely on the contribution of the other players. The point of intersection between all three players depicts the core process of co-constructing care.

This is facilitated by the mental health nurse engaging in a special partnering, recovery-focused relationship with the client aided by a collaborative relationship with other professional disciplines. In addition, the mental health nurse takes responsibility for the coordination of this care, the skill for which emanates from their distinct practice and nursing orientation to care.

A diagram depicting recovery-focused care would have the client at the centre. However, the purpose of this study is to depict a model of mental health nursing practice that facilitates positive outcomes for clients. Therefore, it is not about recovery alone, but the interaction and interdependence that is in play to highlight the distinct contribution of mental health nursing in that process.

Explanations of categories and their interactive contribution to an identified psycho-social process of mental health nursing practice facilitates the generation and integration of theory, tentatively titled:

*Being 'in the here and now, side by side, co-constructing care: a substantive grounded theory of recovery-focused mental health nursing.*

***Regular bulletins will keep you updated with the progress of this research study.***  
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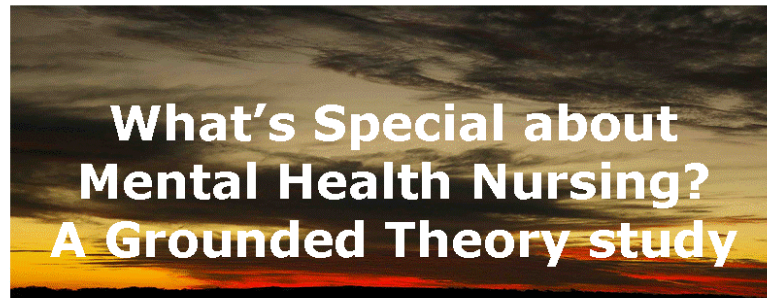
**Chief investigators:** Professors Denise Fassett and Nicholas Procter

## Appendix 27: Progress Bulletin No 17



Faculty of Health  
School of Health Sciences  
Nursing and Midwifery

**Bulletin No 17**  
**June 2014**



### *What is special about mental health nursing? A theoretical construct*

#### **A quest for an explanatory model of mental health nursing**

This study started with the question 'What's special about mental health nursing?' In a grounded theory context, this question represented a general wonderment about phenomena related to the interaction of mental health nurses with their clients. It explored the nature and scope of this relationship in terms of its positive consequences and distinct contribution to care.

Throughout this process of inquiry, adherence to this initial question as a driver for the exploration of these phenomena, served to preserve a 'general wonderment' until concepts emerging from the data consolidated into discernable categories and an explanation of a psycho-social process. This is evidenced by the title of the study, framed around this question, being used up until the dissemination of the final Progress Bulletins, after which the title could be re-framed to reflect the transformation of the consolidated concepts into an integrated theory of mental health nursing that reflected the emerged data.

The theoretical construct that is a consequence of this process is re-

flected in the following re-formed title:

#### **Being in the here and now, side by side, co-constructing care: a substantive grounded theory of recovery-focused mental health nursing.**

This title brings together an explanation of a process that reflects the distinct contribution of mental health nursing to service delivery and care. In order to explicate this, its component parts require explanation in the context of its preceding categories and their properties along with the core category and psycho-social process. The resultant substantive theory of mental health nursing is the product of interpretations grounded in data from participants and augmented by data from the literature.

Singularly, each significant word or phrase of this theoretical construct has meaning and builds a composite explanation that addresses the question of what is special about mental health nursing.

#### **Mental health nurse identity**

'Being' has two connotations in this construct. Firstly, it relays the

notion of existence or essence of mental health nursing as a distinct identity, and secondly the notion of presence. There was a strong sense of both these notions emerging from the data and reflective of the nature of mental health nursing.

To deal with the first notion, becoming and being a mental health nurse has its foundations in serving others. The work of nursing is often basic care and as a discipline has had humble beginnings. This is expressed in the modesty of its work and consequently the adoption of humility in its practice. Within a nursing paradigm, practice is based on a process of care that acknowledges and responds to client needs as the purpose and rationale for that care. This is a distinct lens acquired by being a nurse, fulfilling expectations of others in order to improve the health and well-being of those in their charge.

Being a nurse means to minister care to soothe, comfort and heal in direct contact and association with their charges. It requires engaging in the everyday, lived experience of their clients and understanding how this experience is complicit in their health profile and consequences.

## Appendix 27 continued

Bulletin No 17 June 2014

### *Being in the here and now, side by side, co-constructing care: a substantive grounded theory of recovery-focused mental health nursing*

This sensitivity to the lived experience of a client's health journey is acquired by purposeful and time intensive contact with them. Nurses learn to appreciate and respect that the lived experience of health issues from the client's perspective provides the potential for and actualisation of real solutions of their health challenges, acknowledging the idiosyncratic nature of health experience.

It involves addressing issues of everyday living which could be executed by anyone however the discipline of nursing brings a professional knowledge and skill to these tasks that make them meaningful in terms of therapeutic care and outcomes. Nursing is charged with addressing issues outside the remit of other disciplines. This is the essence of the task, rationale and identity of nursing.

#### **Distinctive mental health nursing practice**

Because nursing attends to health needs of clients, the discipline of nursing requires knowledge of health conditions with which they are involved. Nurses undergo a curriculum of study that draws knowledge from a variety of disciplines to contribute to its study of

human bioscience. In the case of mental health care, health needs are often imprecise and poorly understood, multi-factorial in their aetiology and, as a consequence, diverse and complex, involving social and cultural as well as biological and psychological issues.

The discipline of nursing must meet these challenges in order to attend to their direct caring role in the process of facilitating healing and recovery. Nursing is primed by its broad knowledge base and experience to see these challenges in a holistic way and are intuitively attuned to meeting diverse needs by practising holistically.

Adopting a life-oriented approach requires a presence with their clients in the '*here and now*' of their clients' health experience. Seeing what is relevant 'today' in the real world of their clients is a consequence of this intimate presence, being there in the immediate life of their clients on their territory both physically, psychologically and socially, '*side by side*'.

More than this, it is informed by this process, by both the expressed needs from their clients aided by this closeness, and from experience of this presence itself and the sensitivity it induces to a

therapeutic partnership that is meaningful to both parties. Mental health nurses engaged in this process are therefore readily accessible to their clients on a number of levels. The care that results is not merely delivered from a professional perspective, but is '*co-constructed*' from a position that respects, honours and responds to the expertise that both parties bring to the relationship.

*'Recovery-focused mental health nursing'* demonstrates a willingness to share the power inherent in the notion of expertness, negotiating interventions and contracting the execution of them based on the acquired experience, knowledge and evidence blended from both players as experts in that particular instance of health need.

It allows practice that is flexible in its boundaries (within professional and statutory constraints), exercises the use of creative interventions beyond a traditionally established evidence-base, and models equilibrium in its professional relationship with clients that is rooted in experience and a world view that is distinctly nursing.

**It is special!**

*Bulletins have aimed to keep you updated with the progress of this research study. For further information, contact the researcher:*

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